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Yoga Therapy and the Health of Refugees

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made. This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Narayan Gopalkrishnan

February 2012

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Abstract

Refugees settling in Australia have many physical and mental health issues prior to arrival, issues that can be exacerbated by the settlement process. In Australia, the health needs of refugees are largely managed through a biomedical approach involving medication and/or psychotherapy and counseling. This approach stems from a clear separation between systems that deal with physical health issues and those dealing with mental health. The biomedical basis for working with refugee health issues has been useful up to an extent as the framework is very effective at disease control and prevention but is not so effective for chronic disease that is linked to multiple behavioral, socio-cultural as well as biological factors. Further, there are a number of other aspects of refugee health that biomedicine is unable to respond to effectively, such as cultural differences in understandings of health and illness, causality and healing, mind/body duality, as well issues of power relationships and structures. There is increasingly within Western medicine an awareness of the embodied interface between the spiritual, the social, the psychological and the biological being. Scholars argue that an integrated or holistic paradigm that incorporates the different aspects of health, including the biological, the psychological, the social and the cultural, would make for far better outcomes in terms of the health of refugees than the biomedical by itself.

This thesis examines the role that yoga therapy, as a complementary therapy, can play in responding to the complex health issues of refugees settling in Australia. The research presented in this thesis utilized qualitative research methodology involving a literature review and document analysis, in-depth interviews and focus groups. The participants included people of refugee background who had taken part in yoga programs in Australia, as well as support workers, medical practitioners and complementary therapists. The thesis describes the perception of the health of refugees settled in Australia among service providers and refugees themselves, and the key factors impacting on this. It further looks at the existing mainstream responses in Australia to the health needs of refugees. It then critically analyses the role that complementary therapies like yoga therapy can play, and concludes that, particularly if they are incorporated within an integrative medicine framework, they have a significant contribution to make towards supporting the health needs of

refugees. The thesis argues that holistic systems that address different levels of being and incorporate biomedical systems as well as complementary and alternative medicine systems (CAMs), such as yoga, massage and tai chi, will support the health needs of refugees in a culturally appropriate and effective way. The thesis finally presents recommendations of strategies for future policy and practice.

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Abbreviations

ABS	Australian Bureau of Statistics
ACY	Advanced Centre for Yoga
AIMA	Australasian Integrative Medicine Association
AMA	Australian Medical Association
AMEP	Adult Migrant English Program
AP	Associated Press
AYUSH	Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
CAM	Complementary and Alternative Medicine
CHE	Complex Humanitarian Emergency
DIAC	Department of Immigration and Citizenship
DIM	Duke Integrative Medicine
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
DoHA	Department of Health and Ageing
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBM	Evidence-based Medicine
ERASS	Exercise, Recreation and Sport Survey
FASSTT	Forum of Australian Services for Survivors of Torture and Trauma
GP	General Practitioner
IAYT	International Association of Yoga Therapists
IDP	Internally Displaced Persons
IHSS	Integrated Humanitarian Settlement Scheme

LLNP	Language, Literacy and Numeracy Program
MSKCC	Memorial Sloan-Kettering Cancer Center
NCCAM	National Center for Complementary and Alternative Medicine
NCTSN	National Child Traumatic Stress Network
NGO	Non-Governmental Organization
NICM	National Institute of Complementary Medicine
NIMHANS	National Institute of Mental Health and Neurosciences
PASTT	Programme of Assistance for Survivors of Torture and Trauma
PMTF	U.S. Surgeon-General’s Task Force on Pain Management
PTSD	Posttraumatic Stress Disorder
QH	Queensland Health
QPASTT	Queensland Programme of Assistance to Survivors of Torture and Trauma
RCOA	Refugee Council of Australia
RMIT	Royal Melbourne Institute of Technology University
ROS	Resolution of Status Visa
RTTF	Refugee Trauma Task Force
SGRH	Sri Ganga Ram Hospital
SMCC	Stanford Medical Cancer Center
SPARC	Sport and Recreation New Zealand
SSWAHS	Sydney South West Area Health Service
TM	Traditional Medicine
TPV	Temporary Protection Visa
UCSF	University of California, San Francisco

UNHCR	United Nations High Commissioner for Refugees
VDHS	Victorian Government Department of Human Services
VicHealth	Victorian Health Promotion Foundation
VFST	Victorian Foundation for Survivors of Torture
WHCCAMP	White House Commission on Complementary and Alternative Medicine Policy
WHO	World Health Organization
YJ	Yoga Journal
YTAA	Yoga Teachers Association of Australia

Introduction: Yoga Therapy and the Health of Refugees

Australia is a nation largely made up of migrants, with around seven million people settling in Australia since 1945 (DIAC 2006). Of these, over a million have been refugees resettling under various humanitarian programs (Mares 2001; DIAC 2006). The 1951 United Nations Convention relating to the Status of Refugees states that a refugee is a person who 'owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his formal habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it' (UNHCR 2007). Many people across the world become refugees due to Complex Humanitarian Emergencies (CHEs), which may be caused by political turmoil or natural disasters (Bakewell 2000; Kneebone and Allotey 2003).

Refugees in CHEs, such as those in Rwanda, Iraq and Afghanistan, often suffer intense physical and mental trauma, torture, deprivation and loss, including the violent deaths of immediate family members (Babacan and Gopalkrishnan 2005; UNHCR 2005; VFST 2007). Even when many manage to flee from the immediate danger of the situation, a process involving loss of family and social networks, assets and their normal livelihoods, they have to often travel through very difficult areas before they can find temporary refuge in a formal or informal refugee camp (Aroche and Coello 2002). Their journey can involve intensely stressful situations dealing with hunger, disease, violence and further loss of loved ones (Gushulak and MacPherson 2006; UNHCR 2007). If and when they reach the camps, which are often very crowded places with insufficient infrastructure, they continue to have to deal with issues of violence, trauma, disease and lack of nutrition leading to issues of chronic stress (Olness 1998; UNHCR 2005). Vulnerable people such as women and children can especially be at risk in many of the camps (Aroche and Coello 2002). The trauma that refugees experience in these situations can have long lasting health implications for them, even after they have been resettled into a country of relative safety and security such as Australia (Babacan and Gopalkrishnan 2005).

As part of its international obligations, Australia has established a system to offer resettlement to refugees from overseas, accepting around 13,000 people every year (FASSTT 2010). Refugees who come to Australia through this system go through a process of settlement that in turn imposes its own challenges on their health outcomes. Aroche and Coello (2002) outline three kinds of challenges faced by refugees in their country of resettlement: (I) torture and trauma issues (ii) migration and resettlement issues, including grieving and losses of living in exile, (iii) normal life cycle stages and personality/family issues. Beiser (1991) presents a model on refugee stress as a product of pre and post migration stress as well as personal resources, social resources and socio-demographic characteristics. He further argues that the post-migration experience, especially in the first two or three years, has a very significant impact on refugees. Some of the challenges relate to their own traumatic experiences and the impact of this on various aspects of their life. Others are related to the losses and demands associated with exile and the process of migration and settlement in a new country. The settlement process can also involve dealing with negative and racist attitudes directed at refugees, including issues of personal and institutional discrimination in the workplace (Colic-Peisker and Tilbury 2007; VicHealth 2007; Fozdar and Torezani 2008; Babacan, Gopalkrishnan et al. 2009; Correa-Velez, Gifford et al. 2010). All of these issues place refugees at a profound disadvantage to negotiate the complex demands of the exile, migration and resettlement processes (Brautigam 1996) and produce significant differences in terms of physical and mental health as compared to other migrants (WHO 1996).

The effects of long term stress and trauma on the health of refugees is largely described in the literature using biomedical terminology with a clear differentiation between physical and mental health issues (WHO 1996; Feldmann, Bensing et al. 2007). The term 'biomedicine' is used here to denote the mainstream medical systems in the West based on the natural sciences, especially the biologic and the physiologic sciences (Stedman 2006). The mental health issues that are described include cognitive symptoms such as disorientation, memory disturbance, impaired reading and poor concentration, psychological symptoms such as anxiety, depression, irritability, aggression, self-isolation and social withdrawal as well as neurovegetative symptoms including chronic pain, lack of energy, insomnia, nightmares and sexual dysfunction (WHO 1996; NCTSN 2005). A number of

clinical studies have demonstrated that posttraumatic stress and depression symptoms are very prevalent among refugees and that the effects of trauma are long lasting and enduring (Tan, Krupinski et al. 1986; Hollifield, Warner et al. 2002; Sabin, Cardozo et al. 2003; Marshall, Schell et al. 2005). The physical health issues of refugees range from vitamin and iron deficiencies to infections and parasitic disease and dental and skin problems (Olness 1998; Tiong, Patel et al. 2006). In addition, a number of the physical health issues of refugees are referred to in the literature as somatization, or the physical symptoms reflective of mental distress as a major part of the presenting symptoms, including chronic complaints such as those of joint or abdominal pain, insomnia, nausea, headaches, sinus and breathing problems, and palpitations (WHO 1996; NCTSN 2005). A number of studies have established that both the physical and the mental health of refugees, as differentiated in the biomedical paradigm, are severely impacted on by chronic stress and trauma (Tiong, Patel et al. 2006; Montgomery and Foldspang 2007; Ellis, MacDonald et al. 2008; Johnson, Ziersch et al. 2008; Lindencrona, Ekblad et al. 2008).

When refugees settle in Australia, their health needs are met through a range of services that are largely based on management through medication and/or psychotherapy and counseling that involves a clear separation between those that deal with physical health issues and those dealing with mental health (DIAC 2008; Forbes, Akturk et al. 2008; QH 2008). The models of refugee health services vary across the different States but generally the physical health issues are managed through hospitals, clinics and general practitioners while the mental health issues are responded to through non-governmental organizations, psychiatrists and counselors (QH 2008). The biomedical basis for working with refugee health issues has been useful up to an extent as the framework is very effective at disease control and prevention (Kiesler 1999). However, the biomedical model is not so effective for chronic disease that is linked to multiple behavioral and socio-cultural as well as biological factors (Kiesler 1999; Cohen 2003), such as the chronic health issues that many refugees have to deal with. Further, there are a number of other aspects of refugee health that biomedicine is unable to respond to effectively, such as cultural differences in understandings of health and illness, causality and healing, mind/body duality, as well issues of power relationships and structures (Morris, Silove et al. 1993; Silove 1999; Aroche and Coello 2004; Helman 2007; Singer 2008). Further,

the dual systems that deal with the body and mind aspects of refugee health also lead to less than ideal situations where physical symptoms may be targeted without taking into account the mental and the emotional bodies or the mental may be managed without addressing the physical experience of mental states (Forbes, Akturk et al. 2008)

Increasingly within Western medicine there is a gradual awareness of the embodied interface between the spiritual, the social, the psychological and the biological being (Jonas and Levin 1999; Gaydos 2001; Libster 2001). Aroche and Coello (2002) argue that an integrated or holistic paradigm that incorporates the different aspects of health, including the biological, the psychological, the social and the cultural, would make for far better outcomes than the biomedical by itself. Many scholars extend this argument to state that holistic systems that address these different levels of being and incorporate biomedical systems as well as complementary and alternative medicine systems (CAMs), such as yoga, massage and tai chi, would be likely to address the health needs of refugees in a culturally appropriate and effective way (Papadopoulos, Lay et al. 2003; NCTSN 2005; Tribe 2005; Woodland, Burgner et al. 2010). Nonverbal expressive therapies have an important place in treating victims of trauma, since they are especially designed to engage with implicit consciousness and implicit memories, and they are very useful when the therapist and patient do not share a common language and culture (Wilson and Drozdek 2004).

CAM systems can work effectively with the issues of refugee health for a number of reasons. They do not just work with a linear view of cause and effect in terms of working with health and illness (Gaydos 2001; Guinn 2001). As such, they are able to work with many of the chronic and long lasting health issues that form a significant aspect of refugee health (Jonas and Levin 1999). Secondly CAM approaches, especially therapies like yoga and tai chi, tend to be based on a process that is empowering to the patient/client/practitioner by enabling them to play a more active part in their own search for health and healing (Young 2001; Forbes, Akturk et al. 2008). This is particularly of benefit to refugees, who often have histories of helplessness and disempowerment through the course of their journeys as well as during the process of resettlement (VDHS 2008; Emerson, Sharma et al. 2009). CAM approaches do not just focus on moving a person from the arena of ill health to that of average health, but they work towards moving people towards the area of

enhanced health, thereby being proactive in terms of their approach to health (Guinn 2001; Cohen 2003). Many CAM approaches also address the issues of cultural diversity by viewing the person within their social and cultural contexts, a view very necessary in the context of refugees' resettlement (Gaydos 2001).

The concept of biomedicine working hand in hand with other CAM approaches is also very appropriate as many refugees come from countries with many healing systems and who are often open to working with a plurality of approaches towards meeting their health needs (Lien 1994; WHO 1996; Culhane-Pera, Her et al. 2007; Fenta, Hyman et al. 2007). A number of the organizations working with refugees in Australia already utilize a multiple approach to refugee health, incorporating CAM approaches with medicine as well as psychotherapy and counseling (FASSTT 2006; QPASTT 2006; VFST 2010). However, there is very little formal government support in the form of funding for these approaches and they appear to survive despite a paucity of funds (QPASTT 2006; Chand cited in Roxon 2007). Further, there is very little research done in the area to understand the benefits or lack of benefits of such approaches and to generate evidence for policy decisions around these issues (Singer 2008). It is in this context that I began to develop the hypothesis that is at the core of this research.

The Path to Yoga Therapy and the Health of Refugees

I grew up in India in a middle-class family with a deep interest in ideas of social justice, humanitarianism and spiritualism. My mother was far ahead of her time and place in society, as she moved from being a traditional housewife to undertaking training in working with children with intellectual disabilities even though it entailed leaving the family for a whole year. She went on to establish the first school for children with intellectual disabilities in our city when she returned. Her influence played a key part in my later decisions to work with marginalized communities in India. However, before that came to be I followed the well-trodden path of a Bachelor's degree in Commerce, a Master's in Business Administration, followed by a steadily rising professional career in the corporate world. I did not see any alternative to this, as our family was not very well off, and I needed to be financially stable in a country that had very little in terms of financial safety nets. By the age of 30, I was very well established in my career, managing large corporate organizations, but deeply dissatisfied with the nature of my work. I thought through my situation

and decided that I needed to move beyond the profit motive, both as an individual and as part of an organization, to work that was meaningful in terms of my principles and ethics.

I had always been a voracious reader and was increasingly influenced by writers like Verrier Elwin, the first anthropologist/community development worker to work with remote tribal (the official Indian nomenclature for Indigenous peoples) communities in India, Mahatma Gandhi, the father of the modern Indian nation, and Swami Vivekananda, a spiritual leader from India who carried the message of yoga to the West at the end of the 19th century. I was also very sensitive to the deep dichotomies in Indian society, whether of class, caste, religion, gender or disability, and wanted to move into an arena of work that involved enabling others to reach their fullest potential.

All these ideas finally brought me to the decision to give up my career in the private sector and move to working in a non-governmental organization (NGO). Unfortunately, the salaries they paid would not have been enough for me to live on in a city, so I decided to join an organization that worked in the rural and remote parts of India. To this effect, I took leave from the company I was working in and travelled to NGOs in different parts of India to find one that would be the best fit with my ideals and the skills I had. Finally I joined Gram Vikas, a large NGO that worked across many tribal and non-tribal areas of the State of Orissa. Orissa has, for many years, been one of the poorest States in India, and the tribal people are among the most marginalized people in the State, on many human development indicators. Gram Vikas worked with these communities in a very participatory manner, incorporating community development principles extensively at all levels of the organization. I spent several years with Gram Vikas, initially working in the head office and later managing an extensive Integrated Tribal Development Project that involved working with over a hundred tribal communities. These years were very exciting and professionally very challenging, and left me with a lifelong respect for marginalized groups as well as an on-going desire to work towards the furtherance of their needs among mainstream societies.

Finally, life circumstances drew me away from Orissa and to Australia where I continued to work in the interests of marginalized groups, especially refugees and

migrants. Ever since my arrival in Australia, 13 years ago, I have been immersed in the refugee experience at a number of levels and in different settings. At a professional level, I first worked as the manager of the Tracing Service of the Red Cross, helping refugees to get back into contact with their relatives in their home countries. This involved in-depth discussions with the refugee clients, about their histories and experiences, to elicit likely details that could be used to help trace the people who were missing. At the same time I, along with other concerned human service workers, helped to set up the Multicultural Development Association, an organization that today provides all of the settlement services for refugees in Brisbane and Toowoomba. I worked on the Board of this organization for many years on a voluntary basis and have been closely involved with the organization, the workers and the refugee clients in many capacities over the last 13 years. As an academic as well as the Director of the Centre for Multicultural and Community Development at the University of the Sunshine Coast, I was also involved as chief investigator in a number of research projects with refugees across Australia for a period of 8 years. Many of these projects were action research projects which went far beyond the ambit of traditional research projects to work in partnership with the refugee groups towards their empowerment. I also continued to work closely with refugee groups to promote their interest to the State Government in Queensland, acting in my role as member of the Multicultural Ministerial Advisory Committee.

At the same time, I have been a regular practitioner of yoga for the last 25 years, having completed my Teacher's Training Certificate in Yoga in 1986. I have continued to teach yoga since then, in India and Australia, to different groups of people including university students, refugees and others. I also completed immersion programs in yoga therapy where I lived for significant periods of time with other yoga practitioners in traditional yoga lifestyle settings and was deeply influenced by the culture and practices that are part of yoga. I developed very close links with a number of practitioners, therapists and teachers of different lineages of yoga in India and in Australia, and continue to interact at many levels with them as an academic, professional, colleague and friend.

This research thesis brings together these two areas that I have been deeply involved with over the years and where I realized that there was a gap in the knowledge base. My work with the refugee services made me critically aware of the issues of refugee

health, and the nature of the systems used to support this. I viewed with some dismay the sharp demarcation in terms of services that dealt with issues of physical health and those that dealt with mental health; a system that I believed was not providing the best possible outcomes to the refugees who were clients of these services. I also became aware of the different complementary approaches, including yoga, being used to support refugee health issues along with the use of biomedicine. I was told by several workers in the area that their clients were benefitting from these CAM approaches, but that government funding was not forthcoming to support these programs, which were often run in an informal way or by making use of volunteer services. Many of the workers also brought to my attention the issue of lack of evidence around the use of these CAMs and the chronic underfunding that these programs experienced because of this. The subject of this thesis was a natural corollary to this, to understand the situation as it exists today and to determine whether complementary therapies like yoga had a role to play in supporting the health issues of refugees.

The Aim of this Study

In this thesis I examine the central research question of:

“What role can yoga therapy, as a complementary therapy, play in responding to the complex health issues of refugees settling in Australia?”

As such I seek to:

- Explore the perception of health of refugees settled in Australia among service providers and refugees themselves and the key factors impacting on this.
- Examine the existing mainstream responses to the health needs of refugees.
- Critically analyze the role that complementary therapies play in providing an alternative holistic framework for refugees, using yoga therapy as a special focus.
- Develop strategies for future policy and practice for policy makers, refugee service agencies, health practitioners and refugee communities themselves.

In developing the aims and objectives of the research, while the focus has been on yoga therapy, it has to be remembered that yoga therapy is part of a suite of

complementary and alternative therapies available, all of which are situated within a contrasting paradigm to the biomedical model. As a trained yoga therapist myself, I chose yoga therapy as special focus, but I wished to explore the broader aspect of CAM approaches including any that refugees participating in the study may have used prior to settling in Australia as well as during and after settlement. The critical analyses that form the foundations of the study apply to CAMS and to yoga therapy as a subset of it. Hence there may be times in which the arguments for CAMS and yoga therapy may be used interchangeably as they belong to the alternative health paradigm being contrasted to the biomedical model. I also needed to place this discussion within its context, which is why I also explored the nature of the health needs of refugees, especially those relating to trauma and mental health issues, as well as the factors impacting on these health needs, both prior to and after settlement.

As noted above, the aims of the study are derived from my personal interest and experience, gaps in knowledge in this field, and a disconnection that I perceived existed between disciplinary approaches to refugee health and my commitment to issues of social justice. In keeping with the value base of my work, I utilized critical, reflective and culturally sensitive methodologies to ensure that the refugee participants in the study were empowered through the research process. I wanted to make certain that the process of the research was a co-generative one in which I learnt from participants. Additionally in reporting of the findings I attempted to reflect the voices and views of the participants as well as my own reflections.

Significance of this Study

This research study is innovative as the first of its kind, using a qualitative framework to examine the impact of complementary therapies on the health of refugees, using yoga as a special focus. While there have been many empirical-analytical studies on the benefits of complementary therapies, and a few international studies on the application of complementary therapy in working with refugees (WHCCAMP 2002; Xue, Zhang et al. 2007; MacDuff, Grodin et al. 2010), and the studies from a critical-emancipatory approach in the area of study are scant. Through this study I seek to add to the growing body of literature in the field, filling a gap in the area of knowledge. The study is innovative and significant in several ways:

- It is the first in Australia to critically examine the role of the biomedical model in responding to the needs of refugees, and examine the role of complementary therapies in general and yoga therapy specifically in this context.
- It fills a gap in the knowledge base where much of the practice of working with refugees, especially those surviving torture and trauma, has involved the use of complementary therapies, but there is not enough research to draw on a body of knowledge about this.
- The themes identified through this research will have implications across Australia as well as for nation-states beyond Australia that are signatories to the Refugee Convention and have populations of refugee entrants as they point to ways in which refugees can overcome their issues of health as an important step towards becoming fully functioning members of the host country. The research is also meant to contribute to and inform public policy as well as create awareness and support for the issues of refugee health.
- The organizations and practitioners working with refugee groups will benefit through this research, as they will be able to examine options for the future direction of their work, and possibly challenge some of the dominant paradigms within which they work.
- Most important of all, the research will contribute to the participants and their communities through enabling their voices to be heard at many levels, from the policy to the practitioners and offering options for transformation through providing health services more in tune with their needs.

Researching Refugees

Studies of refugees and displaced peoples carry special concerns for the researcher. Refugees are a particularly vulnerable population that is at risk for a variety of reasons: traumatic experiences in their countries of origin, difficult camp or transit experiences, culture conflict and adjustment problems in the country of resettlement, and multiple losses-family members, country, and way of life (Smith 2009). Scholarship on this topic identifies the need for inclusive, empathetic and empowering practices (Chile, Dunstan et al. 2003). As Chile, Dunstan et al. (2003) point out, research with refugees has to be based on values of partnership, acknowledgement of power inequalities and respect for personal experience and

local knowledge. However Dona (2007:217) points to the difficulties of doing participatory research with refugees. She argues that the analysis of the lives of refugees outside camps indicates that refugees do not inhabit separate physical or social spaces that can be changed without negotiations with other groups; more importantly, they do not necessarily imagine bounded or shared social environments to be improved, making participatory research challenging.

Scholars identify a number of key issues to address in refugee research. Mackenzie et al. (2007:300) identify that the challenges in refugee research are myriad and arise from a range of intersecting issues including those of power, consent and community representation; confidentiality; trust and mistrust; harms, risks and benefits; autonomy and agency; cultural difference; gender; human rights and social justice; and in the worst cases, oppression and exploitation.

The literature identifies other key issues in refugee research:

- Sensitivity to participants' histories of oppression, political persecution and lack of validation
- Research objectives to be linked to the lived experiences of refugee communities
- Addressing cultural issues, particularly issues of language, religion, ethnicity and racism
- Making multiple cuts in research: peeling the layers of the onion, finding out how a refugee community functions as a whole
- Choosing participatory and engaging methodology, avoiding intensive questioning, surveys and interrogative (authoritative) interview techniques
- Non-compartmentalization of research topics, reflecting the interconnectedness of refugee lives and not treating refugee lives distinct topics
- Needing to devise a way to capture naturalistic talk that happens around the sharing of food and in other informal settings
- Needing to build trust not just with individuals but others in the community (Chile et al 2003, Guerin and Guerin 2007, Higgins and O'Donnell 2007)

This research was undertaken within multicultural Australia where over 22 per cent of the population is born overseas and over 43 per cent have at least one parent born

overseas (ABS 2006). As such, it clearly involved working across cultures and cultural interaction, requiring an understanding of the social and cultural lives of participants. The research subject and the act of writing the thesis are part of a struggle for recognition of alternative and complementary therapies and their role in supporting the health of refugees. The study tried to avoid rhetorical devices that render Western authors active and the 'Others' as secondary. My final aim was to make a positive contribution through research which 1) enables a positive contribution to the lives of refugees; 2) enables a sense of wellbeing and health, particularly with issues of trauma; 3) allows for the recognition of non-biomedical models of health service delivery as being valuable and 4) contributes to better policy making and program design in Australia.

Thesis Map

A complex topic such as this one is composed of many interrelated themes. In writing the thesis I had to deliberate with the best ways to present the multifaceted elements of the research and my findings. The thesis is organized into composite but interlinked chapters. There are eight chapters in addition to this introduction. This section provides a map which will navigate the reader through the thesis, with a brief outline of what is contained in each chapter. The overview provided is not a full summary of the chapters but is meant to act as an orientation to the thesis.

Chapter One, titled *Methodological Considerations*, deliberates with principles and practices of undertaking this research. The chapter presents the methodological choices made in the conduct of the research of this thesis, outlining the aims and significance of the study; philosophical and theoretical approaches to research adopted; role of the researcher, the ethical dimensions facing the research; considerations of research with refugees; methods used to collect data and ways data was analyzed. The chapter explains that I have adopted a critical inquiry approach. Critical approaches seek to create research that challenges the way the world is organized and that emancipatory interest seeks to change social, cultural, economic and political domination. The chapter provides an account of how I conducted the research. In conducting the research, I adopted qualitative research methods as they enabled me to understand people and the social and cultural contexts within which they live. As the study involved vulnerable groups of people I was mindful of research with refugee participants and the chapter details how I used inclusive,

empathetic and empowering practices. I provide details of participants and how I collected and analyzed the data. These dimensions form the research framework of this study.

Chapter Two, titled *Refugees and Health*, examines the context of the refugee experience and delineates key terms in the area of refugees and refugee health. In the first section I draw on the literature to describe the international refugee regime and establish the difference between refugees and asylum seekers. This section establishes the global context of being a refugee and international definitions used to determine refugee status and humanitarian obligations of nation states to refugees. The next two sections explain the concept of resettlement, both internationally and in Australia. I examine the nature of resettlement programs and provide a detailed critique of Australia's refugee resettlement scheme. I then turn my attention to the other key part of this research, which is the broad context of refugee health, including the situations prior to and post resettlement and their impacts on the health of refugees. I identify that 'refugee health' is defined differently depending on whether one is referring to refugees in camp situations or those that are resettled, as the focus of different aspects of health shifts depending on the situation of the refugee. I focus on refugee health in the context of resettlement, particularly of torture and trauma, of living in exile and facing loss and also impacts of settlement stressors on refugee health. Finally, the health system that exists in Australia to support the health of refugees is described and some of the key issues in this area are analyzed. In particular I focus on issues of mental and physical health services, models of health service delivery to refugees, issues of refugee access to health services and the provision of culturally sensitive services, especially interpreters.

Chapter Three, titled *Biomedical Model, CAMS and Refugee Health*, explores the key concepts of different approaches towards health and illness. I examine the biomedical model and point out that it is closely associated with the development of Western scientific tradition and identify that it is reductionist and narrow in focus, causing duality, as for example the separation of mind and body. I provide a critical reflection on biomedicine and deduce the implications of this framework for addressing refugee health issues. I critique its ability to respond to some of the issues that have been presented in the literature including the issues that emerge from the social and cultural environments, as there is an increasing realization that chronic

diseases have multiple behavioral, socio-cultural as well as biological factors. I then go on to analyze complementary and alternative medicine systems, their emerging popularity and increasing engagement with scientific frameworks and systems. The contentious relationship between biomedicine and CAMs is then examined and I introduce the concept of Integrative Medicine as a framework within which different systems can work together.

Chapter Four, titled *Yoga and Refugee Health*, examines the themes that emerged from the document analysis of yoga in the context of its application in supporting the health of refugees. I first present the background of yoga including the different schools of yoga that are practiced. The theories and principles of yoga are then explained and their applications to health as yoga therapy are described. I identify that yoga therapy is an encounter between traditional yoga and Western science that aims to utilize yoga, through specific instruction, in the alleviation of physiological, psychological and/or spiritual pain and suffering. One of the common complaints in the past relating to CAM therapies has been the lack of scientific evidence as to their efficacy (AMA 2002; WHCCAMP 2002), but a number of research studies have been undertaken over the last few decades. I close the chapter with a review of the scientific research and evidence around the therapeutic applications of yoga with a specific focus on refugee health.

Chapter Five, titled *Refugee Experience and Health* presents the themes that emerged from the interviews relating to the refugee participants' experiences of leaving their homes, often in violent and dangerous circumstances. It goes on to explore their experiences in travelling to a place of temporary safety, often in a refugee camp in a country neighboring their home country and their lives there. Finally it examines the themes emerging from the settlement process in Australia and identifies key settlement issues such as language, problems in access to services, issues with Government agencies, racism and discrimination, alienation and isolation, loss of social networks and support systems, and other settlement issues. The final section of the chapter focuses on health issues which participants faced, particularly the chronic health issues that the interviewees are still dealing with. This chapter presents the health context within which mainstream health systems and alternative approaches to health can then be discussed in the next chapters.

Chapter Six, titled *Health and Health Systems*, explores problems and issues with the biomedical and complementary therapies from the perspectives of refugee participants and professionals. The chapter identifies themes relating to the refugee interviewees' experience of the biomedical system, both in their home countries and in Australia, as well as their views of the extent to which their health needs were met by this system. Approaches to health, approaches to body and mind, spiritual dimensions of healing, environmental and cultural impacts on health are explored. Further, their views and experiences of complementary therapies, both in their home countries and in Australia, are explored. While yoga therapy remains the focus for this thesis, this chapter excavates the relevance of other CAM approaches such as massage, aromatherapy, and naturopathy to supporting the health needs of refugees. These themes are also examined in the context of the views expressed by the medical practitioners, complementary therapists, yoga therapists and service providers. The chapter concludes with the views of the participants on medical pluralism and integrative medicine.

Chapter Seven, titled *The Yoga Experience*, presents the themes that emerged from the interviews and the focus groups regarding the experiences of the refugee participants in using yoga as a CAM modality. I begin with the benefits or lack of benefits of the practices, as experienced by the refugee participants and whether their health needs were met through the practice of yoga. Health issues addressed through yoga included physical pain, breathing difficulties, insomnia, anxiety, stress, panic attacks, weight management, reduction of medicine dependency and sense of control and empowerment. Then, I examine the relevance of yoga as a CAM modality and as part of Integrative Medicine, as perceived by the interviewees. This is followed by a discussion of the process of formation, the composition of the classes, as well as the perceptions of the participants as related to yoga. I look at the details of the practices that impacted on the participants, such as the class content, methods of practice, communication methods, use of specialized techniques, regularity of home practice, frequency of classes, availability of child support, and stages of settlement. This is then followed by a closing discussion on some aspects of yoga research that were raised by the participants, including issues of gender, perceptions of yoga as exercise of religion and settlement factors impacting on yoga.

Chapter Eight, titled *Looking Back/Looking Forward*, provides a review and analysis of the overall findings in relation to the key research questions and examine ways forward for future policy and practice. The chapter focuses on the important role that yoga therapy can play in addressing the complex health issues that refugees face and the need to take an integrative approach which enables CAMs to work in partnership with biomedical approaches.

Chapter 1: Methodological Considerations

The research process is a complex one involving many dimensions. Crotty (1998) states that the ‘research invites us in a spirit of openness to its potential for new and richer meanings’. However, any social inquiry raises a number of issues in relation to its approaches, theoretical frameworks, methods of data collection, how the research is undertaken, and how the data was analyzed and presented. It involves ethical aspects and frames the role of the researcher and research participants.

This chapter presents the methodological choices made in the conduct of the research of this thesis. Lincoln and Guba (2000) identify that any research process faces some basic issues such as *axiology* and the values and ethics of research, *accommodation* and the commensurability of different paradigms, action and what the researcher does, *control* relating to who initiates query and asks the questions, as well as the *foundations of truth*, validity; *voice* and *representation*. These are very important considerations which I aim to cover in this chapter. I outline the philosophical and theoretical approaches to research adopted especially reflecting on the context of research with refugees. I then present the ethical considerations faced when undertaking the research, the methods used to collect data and the ways the data was analyzed. These dimensions form the research framework of this research. This chapter also provides the details of the interviews and focus groups undertaken in the course of this research.

Philosophy of Research

To gain an understanding of the context, this research adopted a *Critical Inquiry approach* which questions and uncovers the relationship between people’s everyday meanings with the social environment. This approach assumes that social reality is historically constituted, and produced and reproduced by people within their contexts (Kinsella 2006). The implications for my research was that I used appropriate methods which took account of lived reality, that research is not value free and my own reflections as a researcher were equally important (Flick 2009). In the production of knowledge it suggests that facts cannot be isolated from the domain of values or removed from ideological inscription, that language is central to the formation of subjectivity, that certain groups of people in society are privileged over others and that oppression has many faces (Kinchenloe and McLaren 2005:332).

This approach proposes to expose real relations, disclose myths, create consciousness and lead to social transformation (Sarantakos 2004; Punch 2005). It challenges the separation of research from people's experiences, which exists in the empirical-analytical sciences. As such, critical inquiry sheds light on the relationships of power and domination that exist in social relations, engages those that are seen as oppressive, and focuses on transformation (Crotty 1998).

I adopted the approaches in critical inquiry and stand in opposition to the idea that the world cannot be changed. Critical approaches seek to create research that challenges the way the world is organized and that emancipatory interest seeks to change these relations of superordination and subordination (Murray and Ozanne 2006). Critical researchers assume that social reality is historically constituted, and that it is produced and reproduced by people. Oppression is most effective when people lose a sense of history and their potential to act. Although people can consciously act to change their social and economic circumstances, critical researchers recognize that their ability to do so is constrained by various forms of social, cultural and political domination (Kinchenloe and McLaren 2005). The main task of critical research is seen as being one of social critique, whereby the restrictive and alienating conditions of the 'status quo' are brought to light through reflection. Critical research posits that no research is value free and positivist theoretical perspectives contribute to the maintenance of existing social systems through language and concepts that mask underlying interests. Moreover, a critical approach understands the importance of culture as a domain of struggle where production and transmission of knowledge is a contested process, and what cultural forms are privileged is determined by the power relationships (Kinchenloe and McLaren 2005). Critical approaches provide a vision and an imagination for an alternative future (Murray and Ozanne 2006).

Through the critical inquiry approach I undertook this research in the light of a number of critical issues. These included understanding the lived experience of real people in context: that is refugees in Australia, the global context of refugees, service providers, biomedical health systems, alternative systems of complementary therapies, and yoga traditions for healing. They also involved excavating the order and systems of society and the ways in which particular social groups are oppressed and ways which particular knowledge or ideas are privileged, particularly in the area

of health. Further, they entailed examining social conditions in order to uncover hidden structures, how power is used at different levels as well as examining ways to bring about social transformation in order to improve the conditions that affect our lives (Wolgemuth and Donohue, 2006)

In adopting a Critical Inquiry Approach, all refugees were not treated as a homogeneous category but I took into account a number of elements about the participants including: the histories of their countries and the social and political developments; the reasons for persecution and why they became refugees; nature of ethnic relations in their countries of origin; the unique life experiences of the individual and their lived reality as distinct from anyone else from their community; experiences of social institutions and systems, particularly the treatment by authorities in country of origin; refugee experience, experiences of fleeing, camp life, travel experiences to Australia; settlement experiences upon arrival, individual, personal and demographic characteristics; their hopes and visions of better society and what constitutes a sense of good health (Freeman et al. 2007).

The intention of the approaches taken in this research was to gain knowledge. As noted by Cornforth (1977:189) knowledge depends on practice, the growth of knowledge has a transforming effect on practice. It was my intention that this contribution to knowledge would enable transformation to policy and practice that will support refugee health and empower refugees to act for themselves. In taking a Critical Inquiry Approach, I heeded the words of Kincheloe and McLaren (2005:317) who argue that we need a ‘critical humility’ and a ‘criticality’ for a new millennium. This means taking a non-colonial approach to research starting with the assumption that Western societies are democratic but not unproblematic or free from power structures. I acknowledge that this research took place in Australia in the context of major debates which vilify and demonize asylum seekers (Briskman 2009) and cast doubt on the genuineness of refugees in a very discriminatory and racially charged manner (Babacan and Gopalkrishnan 2008). My starting point was acknowledgement of the genuine stories of refugees, the recognition of hardships faced in countries of origin and the difficulties of settlement in Australia. In that sense my research was ‘partisan research’ in contrast to research which is ‘neutral in academic culture’. It aimed for a ‘critical emancipation’ which exposes forces that prevent individuals and

groups who are marginalized from shaping decisions that affect their lives (Kinchenloe and McLaren 2005:304).

These formed my research framework which, as Neuman (2003:62) states, is either an orientation or far-reaching way of viewing the social world. My research framework was underpinned by a commitment to the development of Australia's multiculturalism, human rights, anti-racism and immigrant and refugee settlement, wellbeing and holistic health service delivery.

Qualitative Research Methodology

The methodology is the strategy of inquiry moving from the framework of the philosophical paradigm to the research design and collection of data. However, Charmaz (2006) reminds us that research is not a linear process, but a method of discovery that takes divergent pathways. The choice of research method influences the way in which the researcher collects data. Specific research methods also imply different skills, assumptions and research practices. This research utilized *qualitative research methodology* which, broadly defined, means 'any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification' (Corbin and Strauss 2008). The motivation for doing qualitative research, as opposed to quantitative research, comes from the observation that qualitative research methods are designed to help researchers understand people and the social and cultural contexts within which they live. Murray and Ozzane (2006) point out that the research techniques need to not lose sight of the humanistic element in research by over emphasis on rigid techniques. Kaplan and Maxwell (1994) argue that the goal of understanding a phenomenon, from the point of view of the participants and its particular social and institutional context, is largely lost when textual data are quantified.

I found Kinsale's (2006) key points useful in utilizing a qualitative research methodology. She notes a number of features: that the research *seeks understanding* of the key research questions and the methods need to be appropriate to achieve this end. My research was about understanding the experiences of refugees especially those relating to health and it was clear that quantitative methodology was not going to give me a full understanding. Another feature of Kinsale's argument is that the research is a *situated location of interpretation*. This

means that people who participate in the research process are situated in their environments, including the researcher, and this is recognized in the research process. I took account of this point by allowing different points of view to emerge in the research while being cognizant of the location of participants. The qualitative research was not to find one unique bird's eye view but understanding the uniqueness of each vantage point as relevant and taking account of this in interpretation of the data. I noted that qualitative research is not about rigid processes and systems which are considered objective but that *inquiry as conversation* can take place. The understanding that is sought through the research process comes out in rich and full detail if conversation is free flowing, not restricted by too strict a form. In doing this I paid attention to the *role of language and history*, as these both enable and limit the understanding that we seek. This resulted in paying careful attention to words I selected in the interview questions and understanding the social-political aspects associated with terms such as biomedical, refugee, health and complementary medicines. I mediated the discussion so that we could have common language to facilitate understanding. Finally I was *comfortable with ambiguity* throughout the research. Qualitative approaches enabled this ambiguity to flow through. Ambiguity in my research was present in a number of ways such as paradoxical viewpoints of participants, uncertainty of opinion or lack of information on some issues as well as differing life experiences.

Ethnographic Methodology: My research philosophy, as outlined in the introductory chapter, lends itself to being sensitive to research with refugees. I took on empowering approaches and used methods which are participatory, incorporating methodologies which accounted for lived experiences and histories of refugees. I used *Ethnographic methodology* to enable cultural sensitivity and valuing of diversity, through immersion in the lives of the people being studied and the placing of phenomenon in their social and cultural context (Lewis 2003). Ethnography is useful in understanding facets of life in complex human societies, such as culture, kinship, and relationships (LeCompte and Schensul 2010). Vidich and Lyman (2000:38) note that ethnography is 'born out of concern to understand the Other'. Spradley (1979:iv) suggests that it is a useful tool for 'understanding how other people see their experience'. He emphasizes, however, that rather than *studying people*, ethnography means *learning from people* (Spradley 1979:3). This research

was very much about the Other, which may be defined in various ways: Other as refugees, Other as non-mainstream, Other as culturally diverse, Other as minorities, and Other as alternative approaches to health. In keeping with epistemological approaches adopted, I did not assume the role of expert but was part of the research process, constantly learning from the people I spoke with. My engagement in this research gave me many new insights and enabled me to grow as a result of this engagement.

Ethnography was useful as a methodology in this study for a number of reasons. It enables a study of people's actions, and accounts in everyday contexts. It also enables data to be gathered from a range of sources as also allows focus on smaller or particular settings. The data analysis involves interpretation of meanings and consequences of human actions and institutions. Finally it examines how human actions are implicated in local and wider settings (Atkinson and Hammersely 2007).

Data can be collected using various methods as interviews, documents, participant observation as well as social contacts with people (Grills 1998). This also allowed focus on giving voice to the interviewees, enabling them to speak for themselves as individuals and allowing for the textual aspects of qualitative data to be presented, as with quotations (Alasuutari 1995). As I will discuss in more detail later in the chapter, two of the methods adopted in this research were in-depth semi-structured interviews and focus groups. I viewed these as methods of empathetic understanding that allowed me to move away from my cultural and social position into the other's viewpoint and allowed for intercultural understanding (Dilthey cited in Shields 1996).

The incorporation of ethnographic approaches in working with refugees is important as

as they are least likely to lead researchers to impose their own reality on the social world they seek to understand. Secondly the process of understanding action is omitted from other forms of research and how and why people change is not understood. Third, during interviews, there may be language or cultural views expressed. In this case, observers may record their own experiences in order to understand the cultural universe which people occupy

(subjective experiences) and convey these observations to a wider audience (from field notes) within the context of explaining their data (theoretical framework).

(May 1997:137-138).

This approach enabled me as a researcher to function in a multiplicity of roles as interviewer, facilitator, participant, observer or observer as participant, among others. An important additional benefit of the ethnographic approach is that it allowed for definitions of concepts as participants defined them, for example notions of family, household, self, and community without having to rigidly define it and make assumptions about what these constitute.

I noted that the histories of individuals and communities are the product of collective and individual memories and experiences. However, I also acknowledged that these memories are 'selective' or 'selected' (Taylor 1996). Taylor (1996:13) states that 'since nobody can remember everything, memories that are no longer important to the present are dropped to make room for new ones and old stories get reworked to suit present needs'. Factors which lead to reworking of stories include: change in political circumstances; pain involved in telling the story; fear of repercussions or backlash; lack of skills to articulate; new developments/interests in the community; emotions (guilt, shame, fear) and forgetfulness.

Access to participants requires building trust. Developing relationships and building trust are the key features in ethnographic research (Grills 1998). This enables the researcher to form empathy with their participants, as he or she needs to gain access and build trusting relationships in order to do research. This is particularly important in research with refugees as their experiences of trauma, persecution and grief can make them suspicious of any authority. Through gaining trust and building relationships and links, participants in the research are empowered. This is very consistent with the critical and emancipatory theoretical framework where the research can be used to further the interests of the participants.

I was enabled to enter the lives of the participants and to engage with them in a position of trust by a number of factors. As discussed in the introductory chapter, I have worked with refugees in a number of roles and had the good fortune of

personally knowing and being friends with many people who have gone through the refugee experiences themselves. Because of this and because I had strong networks with the communities in Australia, I was able to approach the refugee and other participants relatively easily. As one of the yoga groups was run on the premises of an organization I have worked with closely for many years, I was able to interact with the participants outside the classroom situation and engage with them in a more informal manner. The experience and skills I have acquired in working cross-culturally were also of key importance in enabling me to connect with the refugee participants and to build enough trust for them to speak to me about issues that were very personal and sensitive in nature. The support garnered from long term relationships with community leaders and service providers was also very useful to develop relationships in the research process. The fact that I had experienced the process of migration myself was also a commonality that helped in building confidence in the refugee participants. My own experience as a yoga therapist and teacher were also a factor in the building of trust as I was able to relate to the issues involving yoga therapy when they were raised by the participants. I was also open to and familiar with the non-Western concepts that often formed part of the discussions.

I engaged in continuous learning and review and, as Eide and Allan (2005:4) note, was willing to 'exhibit culturally appropriate communication and willingness to learn'. In my research methods I used 'trusted others' such as community leaders, support workers and key people to gain trust and build rapport. I tried to avoid any kind of authoritative, 'expert' role and ensured the questions were asked in a sensitive and soft manner, not in an interrogative style. My probes were not direct and ensued from the flow of conversations. I attempted to develop the 'naturalistic talk' (Higgins and O'Donnell 2007) through informal settings and conversations. This is in line with a 'bottom up approach' which is strongly recommended for refugee studies (Voutira and Dona 2007). The participants told their 'stories' as part of the data collection process. As Eastmond (2007:248) states

narratives are not transparent renditions of 'truth' but reflect a dynamic interplay between life, experience and story. Placed in their wider socio-political and cultural contexts, stories can provide insights into how forced migrants seek to make sense of displacement and violence, re-establish

identity in ruptured life courses and communities, or bear witness to violence and repression.

I accepted that stories are part of everyday life of refugees and constitute a means to express and negotiate their experience and have used it as a mechanism to collect data and to develop rapport with participants.

In this study, I acknowledged that research takes place in the context of power relationships, between researcher and participants as well as between the researcher and the society at large (Stanfield and Dennis 1993). I also acknowledged that the question of power in the research process is a difficult to resolve. For example, Salazar (1991:100) states

The demand that the Other expose itself (vulnerability) and the desire to know (power/knowledge) that guides the ethnographic project inevitably creates a hierarchical field of forces that opens up different discursive positions for its participants to take up.

The very act of trying to 'give voice' can deny power in the research relationship. Cultural groups have become suspicious of research due to the way findings are represented, voice is given and the distribution of research (Weenie 2000). My study adopted the view that the researcher cannot adequately and accurately represent the voices of participants. I also did not attempt to homogenize cultural groups or generalize about particular groups (Smith and Morrisette 2001). The practice I followed is one where the researcher can 'speak of ' but not 'speak for' the participants. This approach is supported in a number of areas of research with disadvantaged people. For example, the Council for Aboriginal Reconciliation (CAR 1994:31) notes that

A willingness to speak of Aboriginal and Torres Strait Islander peoples, but not for them, makes possible an exchange of knowledge by creating a common ground for speaking and listening.

In this sense, research is not about the search for a single, monolithic truth but multiple layers of realities (Glassner and Hertz 1999).

I need to make some comments on gender and research as all the refugee participants in the research were women due to reasons that I will outline later. Feminist research

methodology raises awareness of the social construction of gender and alerts us to the gendered nature of power relations. While defining feminism is complex and not within the scope of this thesis, there are a number of key ideas which are central to this work: (a) a belief that women universally face some form of oppression or exploitation; (b) a commitment to uncover and understand what causes and sustains oppression, in all its forms and (c) a commitment to work individually and collectively in everyday life to end all forms of oppression (Maguire 1987:79). In my research, as outlined in different parts of this chapter, I have addressed issues of power in the research, deliberated with issues of advocacy and overall my research contributes to social change. I have at the outset rejected positivistic research which is criticized by feminist researchers. The starting point for me in adopting feminist research principles was the lived experience of the women and their voice in the interview and focus groups. My methods were gender sensitive and allowed narrative, story and biography to be a key part of the interview process. I tried to ensure that there was an accurate representation of their 'story' and their experiences to come through (Allen 2011). I was cognizant that I was a male doing this research, and that my role as researcher, my location as a researcher was part of the process. Reflexivity was a critical issue for me (Finlay and Gough 2003).

In the research process I attempted to allow for what participants wanted to share and allow for a natural synergistic flow of conversation rather than a probing, interrogation style encounter. I chose comfortable locations for participants. I engaged in the use of storytelling as a technique. As the research was conducted in surroundings selected by participants this also assisted with minimizing spatial hierarchies. During interviews, checks were made with individuals about their comfort levels with interpreters being present. Participants were allowed to contribute to the interviews by a freedom to discuss issues of their own that were not included in the interview schedule. These minimized the power dimensions.

As a deliberate strategy towards enabling the voices of the refugee participants to be heard and to inform in a primary way the framework for this study, the perspectives of the refugee participants have been privileged above other participants. As such the interviews with the other participants, such as service providers, medical practitioners, yoga therapists and complementary practitioners, largely provided data

that substantiated or deepened the discussion as heard from the perspectives of the refugee participants. They provided triangulation and enabled discussion of some areas that the refugee participants were not necessarily cognizant of. However, the main voice in this thesis remains that of the refugee participants.

Voutira and Dona (2007) argue that one of the characteristics of the field of refugee studies is the consideration of the reciprocal position and inherent relation between scholarship and advocacy. They point out that this is not mutually exclusive and that if there is argument to contrary then the definitions used of either scholarship or advocacy are limited. Dona (2007:210) reminds us that refugee research

is 'partisan', rather than neutral, to the plight of the subjects of its investigation: studying the experiences, causes and consequences of displacement is done with the implicit or explicit intent to influence the development of better policies and programmes on the part of governments, non-governmental and inter-governmental agencies and refugee community organizations

Similarly, Mackenzie et al. (2007) argue that researchers should seek ways to move beyond harm minimization as a standard for ethical research and recognize an obligation to design and conduct research projects that aim to bring about reciprocal benefits for refugee participants and/or communities. I agree with these points of view about my research benefiting refugee communities. While adhering to rigorous qualitative research processes, I am also advocating for holistic approaches to health and pluralistic medicine options for refugees. The overall aim is to assist in the development of policies and programs that will see improvements in health and refugee services.

Ethical Considerations

Ethics is a vital part of every research project (Alston and Bowles 1998:21) and all research has an ethical-moral dimension. Codes of ethics and other researchers provide guidance, but ethical conduct ultimately depends on the individual researcher (Neuman 2003:116). Researchers have a responsibility to accurately represent themselves and their sponsors (Dane 1990:58). Above all, the researcher has a moral, professional and academic obligation to be ethical, even when research subjects are unaware of or not concerned with ethics (Neuman 2003:116).

While adhering to these research principles, I heeded the words of Mackenzie et al. (2007:300) who argue that the principles of beneficence, integrity, and respect for persons, autonomy and justice are basic considerations in any social science research. They argue that while these principles are important their articulation in research ethics guidelines is often highly abstract and as such they provide insufficient concrete guidance for researchers.

The ethical dimensions that were adhered to in this research included respect for privacy and confidentiality, safety for participants and openness and transparency of the research process. I ensured respect for participants (cultural, personal, and psychological), openness and transparency of the research process and respect for culture, religion, language, gender, age, ability and other factors. I also ensured that no harm is done through the research process, that there was recognition of the barriers to access and equity and belief in the genuineness and dignity of individuals and respect for sensitive issues such as torture and trauma. I recognized that all the participants are equal stakeholders in the research with me as the researcher. I also ensured conformance with standards of ethical clearances obtained from the Curtin University Ethics Committee, as attached in Appendix 1.

In adhering to these principles of research I took on board the arguments put forward by Mackenzie et al. (2007) who argue that researchers need to move beyond standards of ethics committees to the idea of reciprocity. The notion of reciprocity involves negotiating a research relationship with participants that not only respects, but also promotes their autonomous agency and helps re-build capacity. It is argued that the principle of respect for persons entails a responsibility on the part of researchers to try to understand and engage with the different perspectives and life experiences of research participants and to construct research relationships that are responsive to their needs and values (p.301). As demonstrated in other parts of this chapter, I have engaged in relationships with refugee participants in a sensitive, respectful and engaging manner where I have worked on building capacity, information and resources of individuals and communities.

Research Methods and Processes

A methodology is a system of rules, principles and procedures that guide inquiry or investigation in a particular field (Ethridge 2004:25). The meaning of method is ‘the research technique or tool used to gather data’ (Bailey 1978:26). The research method involves a number of players who are all stakeholders: participants, researcher, and relevant institutions and concerned others. Researchers need information from accessing people, settings, and documents (Hesse-Biber and Leavy 2006:15). As noted above, this research is qualitative and concepts take the form of themes, motifs, social phenomena and taxonomies rather than data produced for precise measurement (Neuman 2003:139). Data is gathered from a range of sources and Reinharz (1992:4) points out the importance of research plurality in order to explore diversities. This multi-method approach is consistent with triangulation, which is the use of multiple data sources to explain social phenomena (Klein and Myers 1996).

The following section explains research methods employed in my research which include the following: (i) literature review and document analysis; (ii) interviews; and (iii) focus groups.

Literature review and document analysis

First, a desk-based literature review and document analysis was conducted over four months at the beginning of the study. Literature reviews and analysis of policy documents are an important element of the research process as they uncover what is already known before the research begins (Webster and Watson 2002). This summarizes the body of knowledge in one field and makes sense of the existing research and knowledge on that topic. Neuman (2003) points out that to access a broader picture many researchers use secondary sources which serve as source of valuable alternative information.

Before embarking on empirical research I reviewed the relevant literature sources that included various theoretical approaches and discussion, most notably on health systems and models, refugees and migration, settlement, wellbeing and complementary therapies including yoga.

Print and electronic searches were conducted accessing different university libraries and using a range of databases including academic books, academic journals,

complementary therapy publications, policy and other government documents, community agency reports and newspapers and booklets.

Key words used to conduct searches included 'migration', 'settlement', 'ethnicity', 'refugees', 'refugee health', 'yoga', 'yoga therapy', 'complementary and alternative medicine', 'complementary therapy', 'health systems', 'biomedical models', 'medical plurality' 'integrative medicine', 'wellbeing' and 'health policy'.

The literature and policy document search yielded outcomes which support my thesis and provided:

- Theoretical foundations on key concepts
- Foundational and conceptual materials to guide methodology
- Findings from existing research on relevant topics
- Existing policy and settlement programs
- Statistical data.

The findings from the literature review and document analysis served to guide the broad questions for the interviews and focus groups. This was expanded through the course of the research by further searches to incorporate more recent research and data.

Interviews (face-to-face)

Interviews are probably the most commonly used method of collecting qualitative data in social research (Seale 2002:102). 'Face-to-face' interviews provide good response rates and permit substantive and complex questions to be explored (Neuman 2003:288). I conducted face-to-face interviews in two locations, namely Melbourne and Brisbane, with five groups of participants.

Sampling deliberations: The sample size was a difficult question to determine. Moser and Kalton (1979) point out that a large sample size is not sufficient to guarantee accuracy. Neuman (2003) notes that there are two ways to calculate sample size: through a statistical calculation of acceptable errors and through the 'rule of thumb'. As the first option relates more to quantitative sampling, the second option was adopted, although it is not a totally satisfactory approach to determining sample size. Alston and Bowles (1998) offer a useful contribution by suggesting that

sampling may be continued until no new information is emerging from the research techniques used. This insight was useful in helping me to determine an appropriate sample size that fits well with a purposive sampling technique.

I was working with a small community and the limitations of doing a random approach (for example every fourth person) would not allow me to obtain a range of views and yoga experiences by refugees. For this reason, a purposive sampling was adopted. Purposive sampling uses the judgment of an expert in selected cases with a specific purpose in mind. Neuman (2003) points out that this is a much more acceptable kind of sampling for special circumstances. Purposive sampling is used when the researcher uses it to select unique cases that are especially informative; the researcher may use it to select a difficult to reach specialized population; and when the researcher wants to identify particular cases for in-depth investigation. I further developed a sample based on the snowball technique, when ‘the researcher begins with one case, then based on information about interrelationship from that case, identifies other cases, and then repeats the process again and again’ (Neuman 2003:545).

In addition to the refugee participants, I used the snowball technique to interview medical practitioners, support workers, yoga therapists and complementary practitioners who had worked intensively with refugees, so as to get their perspectives on the health issues of refugees as well as on Biomedicine, Complementary and Alternative Medicine and Yoga. These interviews provided a wider perspective on the points of view discussed by the refugee research participants of this study as they were able to discuss the issues impacting on all their refugee clients across gender, ethnicity and age. As such they were able to provide substantiation to the findings as emerging from the perspectives of the refugee participants and overcoming some of the limitations of the sample spread. The details of the interviewees are provided later in this chapter.

A total of 32 interviews were conducted with:

- Refugees: who had entered Australia from diverse countries and who had undertaken the practice of yoga
- Support Workers: who had worked with refugees in different support and advocacy roles

- Medical Professionals: as health practitioners who worked with refugees
- Complementary Therapists: who worked with refugees
- Yoga Therapists: as complementary therapists who had used yoga to support refugee well-being

The following table provides a breakdown of interviews and location:

Table 1.1: Interview Schedule

Interviewees	Number of Interviews	Location
Refugees	15	8 Melbourne, 7 Brisbane
Support Workers	6	3 Melbourne, 3 Brisbane,
Medical Profession	5	2 Melbourne, 3 Brisbane
Yoga Therapists	4	2 Melbourne, 2 Brisbane
Complementary Therapists	2	1 Melbourne, 1 Brisbane
TOTAL	32	16 Melbourne, 16 Brisbane

These two locations were selected as they were the only two places that I could find in Australia where refugees had been able to access yoga as a therapy. This provided valuable insights and allowed for the lived experiences of refugees to be shared. I developed research instruments for interviews which were a broad set of questions and themes. As I did not want to be too prescriptive but allow the responses to form my theory, an interview guide was developed for different interview groups which was semi-structured and open-ended (refer Appendix 4). This guide served the purpose of moving through the key areas that were to be covered, while allowing for participants to expand on their thoughts and experiences wherever they wished to. In-depth interviews were undertaken with participants in relaxed and comfortable environments of their choice including community centres, homes and offices. Alston and Bowles (1998:117) consider ‘in-depth interviews’ to be the most flexible type of research instrument and suggest that they are frequently used in qualitative research. This technique provided participants with the opportunity to talk about what is important to them, they were free to tell their stories, and offer their perceptions, feelings and experiences and provided an effective mechanism for data collection. In keeping with principles of cross cultural research, I considered all cultural sensitivities including respectful addressing of people, appropriate seating

arrangements (elder status, gender) and allowing for different concepts of time (Laverack and Brown 2003).

Interpreters were used as some participants did not speak English at all or did not speak English well enough to communicate some of the complex ideas examined in this study. Interpreters provide an additional challenge in the research process. Hsieh et al. (2010) have a number of issues in using interpreters in health care and research situations. These include interpreter competence, interpreter trust, shared goals and professional collaboration. In relation to interpreter competence I ensured that the interpreters were appropriately accredited as professional interpreters and understood their ethical and professional obligations under the interpreter code of conduct. I am aware of issues of trust and in small communities the interpreter may be known to participants. I asked all participants if they were comfortable with having the particular person as the interpreter and only proceeded if they gave consent. I did not have any participants refusing an interpreter and several of them stated that they were glad to have facilitation in their language. I briefed the interpreter, providing an explanation of the key terms and concepts and going through the interview questions. Concepts may not always translate well across different languages so we discussed whether this was the case. While the term 'complementary therapies' did not exist in any of the languages they had alternative terms such as 'traditional remedies' which were substituted. I forged a good working relationship with the interpreters which enabled positive professional collaboration.

The following section presents further information on the background of the interviewees. It identifies the country of origin, period of residence in Australia, age, marital status, religion, English proficiency and interpreter use, education and employment status. The participants are identified by pseudonyms in this section and throughout the thesis to maintain confidentiality.

Table 1.2: Demographic Characteristics of Refugee Participants

Melbourne Participants								
Name	Dah Eh	Htoo Say	Paw Say	Ler Paw	Dah Gay	Mu Dah	Naw Wah	
Country of Origin	Burma (Karen)	Burma (Karen)	Burma (Karen)	Burma (Karen)	Burma (Karen)	Burma (Karen)	Burma (Karen)	
Period of Residence in Australia	1 year	2 years	1 year	2 years	2 years	2 years	1 year	
Age	40	35	32	36	35	43	52	
Marital Status	Married	Married	Married	Widow	Married	Married	Married	
Religion	Christian	Christian	Christian	Christian	Christian	Christian	Christian	
English Proficiency	Through Interpreter	Through Interpreter	Through Interpreter	Through Interpreter	Through Interpreter	Through Interpreter	Through Interpreter	
Formal Education	None	None	None	None	7 th Grade	4 th Grade	Trained Nurse	
Formal Employment	None	None	None	None	None	None	None	
Brisbane Participants								
Name	Hasina	Kesi	Musu	Josephine	Mahtab	Zainab	Neda	Shalini
Country of Origin	Sudan	Sudan	Liberia	Rwanda	Iran	Iraq	Afghanistan	Sri Lanka
Period of Residence in Australia	4 years	2 years	7 years	2 years	4 years	10 years	7 years	11 years
Age	32	42	52	30	28	44	30	43
Marital Status	Married	Married	Widow	Married	Married	Widow	Single	Married
Religion	Muslim	Christian	Christian	Christian	Baha'i	Muslim	Muslim	Hindu
English Proficiency	Through Interpreter	Through Interpreter	Fluent	Through Interpreter	Fluent	Through Interpreter	Fluent	Fluent
Formal Education	None	3 rd Grade	High School	4 th Grade	High School	5 th Grade	High School	High School
Formal Employment	None	None	Employed	None	Employed	Employed	None	Employed

Countries of Origin: The yoga group in Melbourne was the only yoga class in Australia that was being run regularly for refugees in Australia, and it was important to interview the participants of this group. All of these were from the Karen community, originally from Burma (now known as Myanmar), and as such seven of the interviewees are of Karen background. The other eight were from two Brisbane yoga groups. The Brisbane interviewees came from diverse backgrounds. The

participants from the African continent included two from Sudan, one from Rwanda, and one participant from Liberia. From the Middle East, there was one participant from Iran and one from Iraq. Finally there was one participant from Afghanistan and one from Sri Lanka.

Period of Residence in Australia: The refugee participants in this study represented a wide range of periods of settlement in Australia. The Melbourne group was very cohesive in this regard. All of the seven Karen interviewees had been in Australia for periods ranging from one to two years, placing them all within their initial periods of resettlement. The Brisbane interviewees had been in Australia for longer periods of time representing different stages of settlement. The shortest length of residence in Australia was two years for Josephine and Kesi, going up to 11 years for Shalini.

Gender: All the refugee participants in this study were women. The original purpose of this research was to have a gender balance in the sample. However, in the course of excavating for prior refugee groups that had participated in yoga, I found that only women had participated in yoga classes. This finding supports the data from the literature which reveals that the yoga participation ratios of women to men in Western countries ranges from 72.2 per cent in the United States to 90 per cent in Australia in favor of women (YJ 2008; SPARC 2009; ABS 2010). While some explanation of this is also provided in the literature, giving reasons like fear of embarrassment, inadequacy of yoga in terms of physical and competitive challenges as well lack of knowledge (YJ 2008), this research also provided some opportunity to examine the reasons for this gender bias, and these are presented in the chapter on findings related to yoga.

Age: The respondents in this study conformed closely to the profile of yoga practitioners in the literature where the mean age of practitioners is identified as 37.1 in the United States and 41.5 years in Australia (Penman 2006). All of the refugee participants in this study were between the ages of 30 and 52.

Marital Status: The majority of participants in this study were married. Three of the participants had been widowed in the course of the events that had caused them to become refugees. Neda was the only single person among the interviewees, and lived alone.

Religious Affiliation: The respondents in this study represented a mix of religions. The majority came from the Christian faith, including the Karen respondents, Musu from Liberia, Josephine from Rwanda and Kesi from Sudan. The three of Islamic faith include Hasina from Sudan, Zainab from Iraq and Neda from Afghanistan. Mahtab from Iran professed the Baha'i faith and Shalini from Sri Lanka the Hindu faith.

English Proficiency: Fluency in English was a major issue for most of the respondents, and is discussed in the next chapter as one of the major settlement issues for refugees in Australia. All the respondents residing in Australia for three years or less had to use the services of an interpreter during the interviews. Of those who had been in Australia for longer periods of time, Zainab was the only one who needed an interpreter. Musu, Mahtab and Shalini were fluent enough in English to participate in the interviews without an interpreter.

Levels of Formal Education: The majority of respondents in this study faced significant difficulties in terms of acquiring formal education. In some cases, as in with the Karen participants from rural backgrounds, the lack of availability of schools was the reason for not acquiring an education. In other cases, such as with Hasina in Sudan, the culture was not supportive of girls being educated. Those from urban backgrounds had higher levels of education, the highest that of Naw Wah who is a trained nurse.

Employment Status in Australia: None of the respondents who were in their first years of settlement were employed, even though many of them expressed the desire to work. The reasons for this were mainly related to health issues and lack of fluency in English as discussed later in the findings. Of those who had been in Australia for longer periods of time, Musu was working in a nursing home, Mahtab was working in a departmental store, Zainab was in a factory and Shalini was in hospitality. Though Hasina and Neda had been in Australia for some time, they were both unemployed, mainly due to health reasons.

Details of Medical Practitioners

Of the five medical practitioners, two were psychiatrists, two were general practitioners and one was a nurse. Of these, one psychiatrist, one general practitioner and the nurse were based in Brisbane while the other two were based in Melbourne.

Both the general practitioners worked in clinics with a large number of refugee clients. One GP spoke a language that was also spoken by many of his Afghan clients and he was able to communicate with them without an interpreter.

One of the psychiatrists had a private practice with some refugee clients. She was trained in yoga and had used yoga as therapy for dealing with issues of trauma with Vietnam Veterans. The other was based at a hospital that had many refugee clients. The nurse worked within a refugee health clinic that supported the health needs of refugees mainly in the first six months of their arrival in Australia.

Details of Service Providers: Of the six service provider interviewees, three were based in Brisbane and three were based in Melbourne. In terms of the kinds of organizations represented, three of them were based at organizations providing settlement services to refugees. All three had been working in the area of settlement services in different roles for many years and were very familiar with the issues of the health of refugees.

Two of the service providers were based at torture and trauma services which mainly dealt with the mental health issues of refugees. One of them was a counselor while the other worked very closely with one ethnic community in a number of different roles. One of the interviewees was based at the core of one of the State-wide refugee health services and had a very broad understanding of the health service across the State as well as the health issues emerging in their centralized clinic.

Details of Complementary Practitioners: One of the complementary practitioners was based in Brisbane while the other was based in Melbourne. Both had worked for many years with refugee clients in a torture and trauma service. One was a qualified Homeopath while the other specialized in Naturopathy.

Details of Yoga Therapists: Two of the four yoga therapists were based in Brisbane, while two were based in Melbourne. As there were very few yoga therapists who had experience of working with refugees, I included the interview with Mia among the four even though she had not worked with refugees in Australia. However, she was working currently with Karen and other refugees from Burma (Myanmar) in camps in Thailand, similar to the backgrounds of many of the refugee participants in this study, and she had many valuable insights to add to the themes of this research.

Focus Groups

Two focus groups were held in Melbourne, one with refugee participants and the other with service providers. The focus groups allowed for the exploration of issues and themes in a group environment. It allowed me as the researcher to verify and compare information collected from the interviews. The focus groups provided a way of triangulation, i.e. obtaining input and data from multiple sources, testing and exploring in more detail the findings from the literature review and the interviews (Klein and Myers 1996).

The focus group with refugee participants was organized with the Karen group as they were the group willing to come together and discuss the issues at length. Further, they shared a language and were able to comfortably engage with issues with only one interpreter to help with the facilitation. The advantage of this focus group was that the participants were a group of refugees from the same cultural background who had undertaken yoga classes. This enabled me to obtain the range of experiences relating to yoga therapies without the complications of multicultural interactions and dynamics within the group, had the group been constituted from different ethnicities. Seven of the eight participants of the focus group for refugee participants had previously been interviewed in Melbourne. The only additional participant was Si Poe who was a married woman, 45 years of age, and unemployed with no formal education. She had lived in Australia for two years. She needed the help of the interpreter when interacting with people who only spoke English.

All seven of the participants of the focus group for service providers had worked in organizations that provided services to refugees in Melbourne. Two of the participants were based at migrant resource centres that provided settlement as well as other services such as employment and advocacy to refugee and migrant clients. Two more were from charitable church-based service organizations. One participant was from a migrant employment service, one was from a neighborhood centre with a high proportion of refugee clients, and one was from a community based refugee service funded by the State Government.

All the participants of the focus groups were asked to participate using the formal consent form. The purpose for the focus groups was explained and details were given. The focus groups were held in mainstream community settings that were

considered neutral and non-threatening. The room was set up in a circular manner and refreshments provided. I took extensive notes during the focus groups. Guerin and Guerin (2007) point to the different stages of information gathering in refugee research. They argue that there are 'front stage' responses may be followed by 'backstage' responses. The participation in both interviews and focus groups enables participants to provide the different levels of response, which are equally valid and important and bring a diversity and complexity to findings. The issues that were canvassed in the focus groups are presented in Appendix 5.

Data Analysis

After the collection of data, the next stage was data analysis. The issues of what is written and how data is represented are critical to the outcomes of research. The act of analysis of data and writing is not a simple process in itself and it raises a number of questions particularly about whether the researcher is an interpreter presenting as a 'privileged witness' (Nijhof 1997:56). I noted my role as mediator, translator, traveller, organizer, and orchestrator of knowledge (Chow 1993; Rosaldo 1993). Qualitative data are often in the form of text, written words, phrases or symbols representing people, actions, thoughts, beliefs, behavior and events in social life. Neuman (2003) notes that there is no single qualitative data analysis approach that is widely accepted. Sarantakos' approach (2004) was useful in guiding how the data could be analyzed.

As outlined in Sarantakos' approach, I transcribed each interview as soon as possible after each interview. The process of transcription enabled me to begin the process of categorization. As a first step in the analysis, I reduced the data into thematic codes that were then used to represent the major categories and subcategories. In undertaking the coding, I was open to the feedback and remained close to the data collected, tried to be comprehensive and used short codes for each theme. I took a systematic approach to this as 'coding is the first step towards data analysis and the quality of a coding scheme influences the eventual quality of data analysis' (Seale 2002:326). Some of the final thematic codes I adopted were refugee experiences, settlement issues, health experiences, experiences of health systems, views on biomedicine, views on complementary therapies, experience of yoga therapy and what needed to change(in policy, program, service delivery). I used a tabular format to assign these codes to individual sentences in the transcripts, with the codes in the

first column on the left and the sentences from the transcript in the right column. This intensive approach enabled me to re-examine the data many times to draw out the themes and patterns.

The third phase is interpretation and evaluation; this involves identifying patterns, trends and explanations that lead to conclusions. The third phase is the interpretation phase. This involves a search for patterns in data, recurrent behavior or body of knowledge. Once a pattern is identified it is interpreted in terms of social theory or the contextual information available. In the interpretation phase a number of tools were available at my disposal. One of them is called the successive approximation that involved repeated iterations through the steps moving toward a final analysis. This enabled me to move from broad vague concepts and details in the data to a more comprehensive analysis with generalizations. Another method utilized is the illustrative method in which I applied existing theory to the concrete historical situation (Australia) or social setting (health, refugee, yoga). I specifically analyzed micro (i.e. small-scale and narrow-scope aspects) and macro (i.e. large-scale and broad-scope aspects) data, and then merged relevant issues to answer the research questions. Micro analysis focused on individual elements of refugees and settlement experience, access to health services, experiences with biomedicine and complementary and yoga therapies, while the elements of macro analysis included the broader social and health systems issues, integrated and holistic models of health, and broader considerations about cultural diversity. Bailey (1978:28) considers it is probably not necessary to draw a sharp dividing line between macro and micro elements that are both linked. This perspective was adopted in the analysis and the interlinking of individual and societal factors were explored.

In data analysis I adopted an intermediary course between simplistic polarities (Kearney 2003:187). According to Kearney (2003:187) if we are to overcome the dangers of polarized thinking, in our role as interpreters of data we need to deconstruct "binary dualisms so as to 'muddle through' with the help of a certain judicious mix of phronetic understanding, narrative imagination and hermeneutic judgment". In my data analysis I used practical judgment (from my personal experiences), the value base of my research and the diverse perspectives offered from participants. I attempted to derive a more complex analysis and to go beyond simple

duality of biomedicine or complementary therapies towards looking at a middle ground.

Finally, the data were reviewed at this stage to see if something was missing, overlooked or did not appear, called negative data (Sarantakos 2004). I examined the data further in the context of the themes that emerged out of the on-going literature review so as to deepen the level of analysis. The themes that finally emerged through this process are presented in Chapters 5-7.

Limitations of the Research

In this research, the purpose was to interview refugees who have practiced yoga as a therapy for their health issues, and my sample was accordingly restricted. I had anticipated a balance in terms of the gender and age of the participants and also a spread over different ethnicities, but found that the three small groups of refugees, who had participated in yoga, comprised entirely of women of ages largely between 30 and 52. This raised several issues in terms of the research. As a male researcher, I was aware that some of the women respondents would not be comfortable with discussing issues of health with me. I was able to ease the process to quite an extent by involving female interpreters who the participants were familiar with in the interviews.

Also, half the refugee participants were from one yoga group made up entirely of people of one background, Karen people originally from Burma, while the other groups had participants from diverse communities. This bias in terms of the number of interviewees of one cultural background as well as the gender bias had to be accepted as limitations of the research as I was unable to find any more participants from diverse backgrounds. The only marginally relevant group was a male group of refugees in Brisbane who participated in an exercise-based program in which two sessions of yoga had been incorporated. However, two sessions are not enough to impact on health issues and as such I did not interview the men who participated in these classes. I did, however, interview the support worker who had organized this group to hear her perspective on the health issues of her male group.

Summary

This chapter provided an overview of the methodological deliberations in undertaking this research. I outlined that in the research I adopted a Critical Inquiry Approach which enabled me to take account of lived experiences of participants and to ensure that the research process was empowering for all participants. I drew upon qualitative and ethnographic research methodology to enable the richness of responses to come forward in the tradition of ‘inquiry as conversation’. I provided a breakdown of the research methods which included a literature review, interviews and focus groups. I also outlined the process by which data was coded thematically and interpreted. I ended the chapter with a focus on the limitations of the research and how I addressed these limitations. The next chapter explores refugee experiences with a particular focus on the health of refugees.

Chapter 2: Refugees and their Health

Introduction:

As my research approach places importance in the historical, social and cultural context of research I needed to engage in an understanding of the broader context of refugees and the health of refugees. This chapter examines the context of the refugee experience and presents key concepts in the area of refugees and the health of refugees. In the first section I draw on the literature to describe the international refugee regime and establish the difference between refugees and asylum seekers. The next two sections explain the concept of resettlement, both internationally and in Australia. I then go on to examine the broad context of the health of refugees, including the situations prior to and post resettlement and their impacts on the health of refugees. Finally, the health system that exists in Australia to support the health of refugees is described and some of the key issues in this area are analyzed.

Refugees:

The 1951 United Nations Convention relating to the Status of Refugees (UNHCR 2007) states that a refugee is a person who:

Owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his formal habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

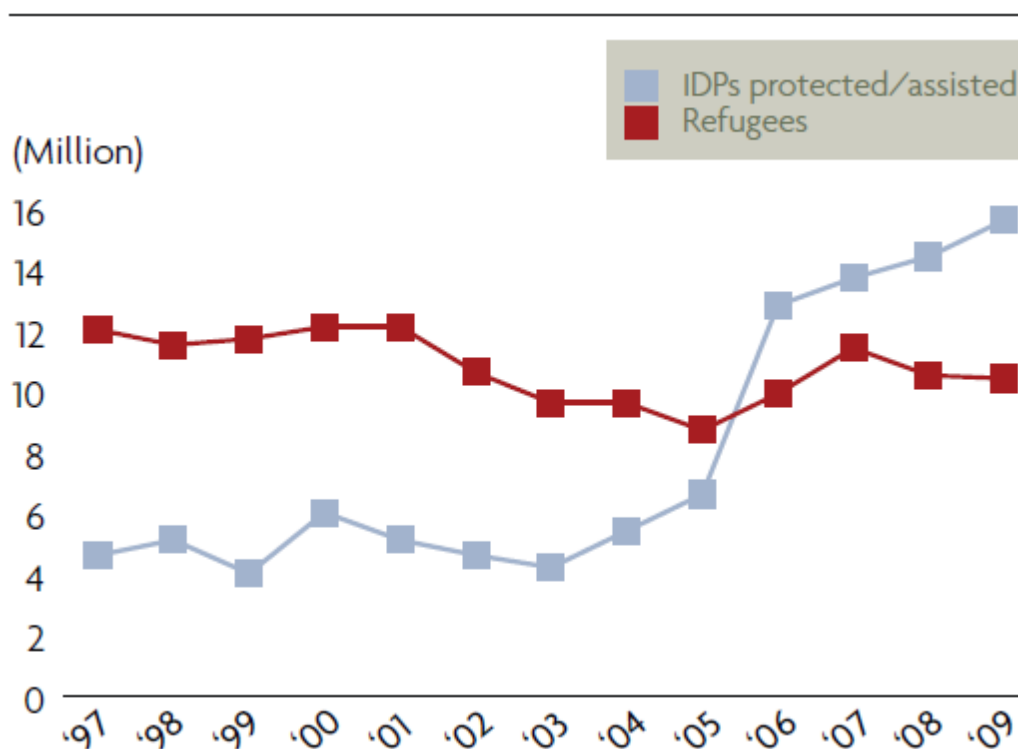
The 1951 Convention is the primary international instrument that establishes the obligations under international law for countries signing the Convention. Initially, this applied to refugee situations of the time in Europe after the Second World War, and had to be extended further under the United Nations 1967 Protocol which strengthened the Convention to cover refugee situations occurring after 1951 in any country (UNHCR 2007; DIAC 2009). The 1951 Refugee Convention and its 1967 Protocol form the international refugee regime and are further supported by other

conventions and protocols such as those against torture and those protecting human rights and women's and children's rights (UNHCR 2005; UNHCR 2007). International action to protect refugees and to resolve refugee problems is led and coordinated by the office of the United Nations High Commissioner for Refugees (UNHCR), established by the United Nations General Assembly on 14th December 1950. The UNHCR has offices in more than 110 countries around the world and has helped over 50 million people (DIAC 2009).

The mass movements of people of concern to the UNHCR are often caused by Complex Humanitarian Emergencies (CHEs), emergencies that may be caused by political or ethnic conflict (Bakewell 2000; Kneebone and Allotey 2003). The conflicts include those between states as well as those within states, as also a mix of the two as in Afghanistan and Iraq. The post-September 11 2001 global 'war on terror' has intensified the issues of conflict, as it has led to several new arenas of conflict, including in Aceh, Chechnya, Georgia, Iraq, Pakistan and Palestine (Loescher 2009). Millions of people are also displaced by environmental degradation and natural and man-made disasters (Bakewell 2000; UNHCR 2005).

The UNHCR takes on the major share of responsibilities of managing refugee crises, while working with a number of other stakeholders, such as national governments and non-governmental agencies. The large majority of refugees are from and in low-income countries, with women and children representing over 50 per cent of the total (UNHCR 2007). While the refugee regime was originally focused on refugees, it has come to include *asylum-seekers* (individuals whose applications for asylum or refugee status are pending a final decision) and *internally displaced persons* (IDPs are refugees who have not crossed an international border) and other groups that do not technically qualify as refugees. The following table highlights the refugee and IDP populations that the UNHCR worked with from 1997 up to 2009.

Table 2.1: Refugees and IDPs protected/assisted by UNHCR, 1997-2009 (end-year)



(UNHCR 2010:19)

By the end of 2009, the total population of concern to UNHCR was estimated at 36.5 million people: 10.4 million refugees; 984,000 asylum seekers; 251,000 refugees who had repatriated in 2009; 15.6 million IDPs protected/assisted by UNHCR; 2.2 million IDPs who had returned to their place of origin in 2009; 6.6 million stateless persons; and 412,000 others of concern (UNHCR 2010:7). The statistics are inadequate as they do not reflect over 4.5 million Palestinian refugees under the responsibility of the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNHCR 2007). Nevertheless, they do indicate the extent of the problem, with the total number of people of concern to the UNHCR three times the number of refugees. Demographic data of persons of concern to UNHCR in 2009 shows children and adolescents under the age of 18 accounting for more than half (56 per cent) of the refugee camp populations in Africa, while they represent 31 per cent in Europe. Children below 5 years of age represent 18 per cent of populations of refugee camps in Africa and 9 per cent in Asia and Europe. Although women make up half the refugee population, they tend to be proportionately higher in refugee camps and lower in urban settings (UNHCR 2010:46-47). Much of the heaviest burden of CHEs falls on the most vulnerable sections of society, the

children including unaccompanied minors, orphans, child soldiers, detainees, children who are heads of households, women and girl survivors of torture and sexual violence, widows, the disabled, the mentally ill and challenged, as well as the elderly (WHO 2008).

Resettlement:

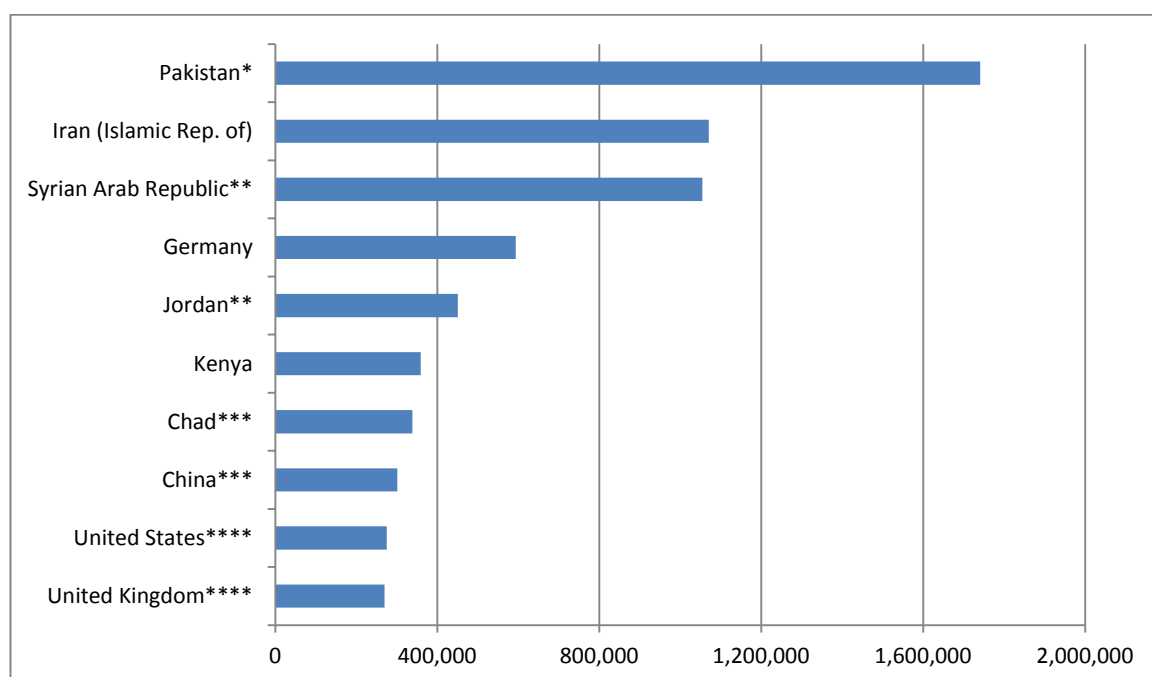
While the majority of refugees tend to stay in neighboring countries, with over 80 per cent remaining within their region of origin, some refugees are resettled into other countries. Resettlement may be defined as the transfer of refugees from a state in which they have initially sought protection to a third state that has agreed to admit them with permanent resident status. The numbers are statistically very small, with, as an example, the UNHCR stating that only 1 per cent of the total number of refugees were resettled in 2007 (UNHCR 2007).

Resettlement is not only an international responsibility-sharing mechanism and a key element in comprehensive solution strategies, but it is also a vital protection tool. It provides protection to refugees who cannot go home or who are unwilling to do so because they fear continued persecution, and whose lives, liberty, safety, health or other fundamental human rights are at risk in their country of asylum.

(UNHCR 2010:30)

The UNHCR states that this was the preferred solution for the settlement of refugees until the mid-1980s and provided the means for settling waves of refugees such as those following the 1956 Hungarian revolution, the crisis in Uganda in 1972, Chile in 1973 as well as the large numbers of ‘boat people’ emerging from Vietnam after 1989 (UNHCR 2005). While resettlement continues as a means of addressing the issues of refugees, other means such as repatriation are being considered as ‘durable solutions’, a trend which may have its roots in the unwillingness of traditional resettlement states to fill their quotas and to expand them further (UNHCR 2005). The following table reflects the sheer size of the refugee populations in terms of the countries of resettlement.

Table 2.2: Main Refugee Hosting Countries 2009



* Includes Afghans in a refugee-like situation.

** Government estimate.

*** The 300,000 Vietnamese refugees are well integrated and in practice receive protection from the Government of China.

**** UNHCR estimate based on 10 years of individual recognition of asylum seekers.

Figures exclude resettled refugees.

(UNHCR 2010:21)

When these figures are broken down by GDP per capita, the UNHCR states that:

The top ten countries based on GDP (PPP) per capita ranking hosted 41 per cent of all refugees worldwide at the end of 2009. In short, the responsibility of hosting almost half the world's refugees is shouldered by ten developing countries.

(UNHCR 2010)

While countries like Pakistan and Iran continue to absorb large numbers of refugees every year, developed nations like Australia and the United States take in limited numbers of refugees through their resettlement programs with the total number of refugees resettled in the industrialized nations in 2009 at 112,400 (UNHCR 2010).

Australia as a country of resettlement:

Aboriginal and Torres Strait Islander people lived across Australia and the islands of the Torres Straits long before the arrival of the first European explorers (Macintyre 2004). European settlement of Australia really began only post 1788, when the first settlers arrived and the penal colonies were set up. The waves of migration that followed were quite diverse in terms of the ethnic background of the settlers, until the early twentieth century (DIAC 2010). In 1901, the federal government passed the Immigration Restriction Act which effectively brought into law what is known as the 'White Australia' policy. This law, through a series of harsh restrictions, sought to try and curtail the flow of non-European migration to Australia (DIAC 2009). Until its modification in 1966 and final abolition in 1973, the 'White Australia' policy ensured that the majority of people settling in Australia were of European background (Neumann 2004). Among these were large numbers of refugees of European background settled in Australia after the Second World War, including more than 170,000 people just between 1947 and 1953 (DIMIA 2003).

Australia was the sixth country to ratify the 1951 United Nations Convention relating to the Status of Refugees and acceded to the 1967 Protocol relating to the Status of Refugees in 1973. The Convention and its definitions are reflected in Australian domestic law (DIAC 2009). By acceding to the Protocol, Australia expanded its obligation from mainly European refugees to all refugees (Neumann 2004), and as such takes in significant numbers of refugees of various backgrounds every year. While the majority of people settling in Australia have come in under the various migration programs, over one million people have been refugees who have settled under humanitarian programs (Mares 2001). As stated by the Department of Immigration and Citizenship, the humanitarian program has two important functions:

It fulfills our international obligations by offering protection to people already in Australia who are found to be refugees according to the Refugees Convention (known as the onshore protection/asylum component). It expresses our commitment to refugee protection by going beyond these obligations and offering resettlement to people overseas for whom this is the most appropriate option (known as the offshore resettlement component).

(DIAC 2010)

Australia maintains a quota system in terms of its humanitarian effort, with the quotas evolving and varying in numbers over time. The total quota remains unfilled often, depending on the political focus in Australia at the time (Neumann 2004). The following table presents the visas granted against this quota over the last decade.

Table 2.3: Humanitarian Program grants by category 2001-02 to 2009-10

Category	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010
Refugee	4160	4376	4134	5511	6022	6003	6004	6499	6003
Special Humanitarian (Offshore)	4298 ²	7280	8927	6585	6736	5183	4795	4511	3233
Onshore ¹	3885	866	788	1065	1372	1793	2131	2492	4534
Temporary Humanitarian Concern	6	3	2	17	14	38	84	5	--
Total	12349	12525	13851	13178	14144	13017	13014	13507	13770

¹Protection visas and onshore Humanitarian visa grants countable under the Humanitarian Program.

²Includes 40 Special Assistance visas

(DIMIA 2002; DIMIA 2003; DIMIA 2004; DIMIA 2005; DIAC 2010)

As may be seen in this table, the annual intake under the refugee and humanitarian program in the last decade has generally been over 13,000 with approximately 6000 places set aside for those who meet the legal definition of being a refugee, while 7000 places are for those who come from a refugee-like background and who have a sponsor in Australia (FASSTT 2010). The regions from which these refugee groups have originated have changed quite dramatically over the years and some of these changes may be noted in the following chart.

Table 2.4: Breakdown of Humanitarian Arrivals to Australia by region from 1998-2009

	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
1998-99	Europe 49.72%	Middle East and SW Asia 30.64%	Africa 16.29%	Asia 3.10%	Americas 0.25%
1999-2000	Europe 45.64%	Middle East and SW Asia 29.83%	Africa 22.69%	Asia 1.56%	Americas 0.28%
2000-2001	Europe 43.32%	Middle East and SW Asia 26.96%	Africa 25.43%	Asia 3.95%	Americas 0.34%
2001-02	Africa 33.12%	Middle East and SW Asia 32.43%	Europe 32.03%	Asia 2.23%	Americas 0.19%
2002-03	Africa 48.32%	Middle East and SW Asia 39.94%	Europe 9.93%	Asia 1.78%	Americas <0.1%
2003-04	Africa 70.78%	Middle East and SW Asia 24.29%	Europe 3.00%	Asia 1.87%	Americas <0.1%
2004-05	Africa 70.16%	Middle East and SW Asia 26.24%	Asia 3.43%	Europe 0.16%	Americas <0.1%
2005-06	Africa 55.65%	Middle East and SW Asia 33.98%	Asia 9.88%	Europe 0.43%	Americas <0.1%
2006-07	Africa 50.91%	Middle East and SW Asia 27.95%	Asia 20.70%	Europe 0.44%	Americas <0.1%
2007-08	Middle East and SW Asia 35.5%	Asia 33.7%	Africa 30.5%	Europe 0.6%	Americas <0.1%
2008-09	Middle East and SW Asia 33.5%	Africa 33.2%	Asia 33.1%	Europe 0.1%	Americas <0.1%
2009-10	Asia 38.6%	Middle East and SW Asia 31.8%	Africa 29.2%	Europe 0.3%	Americas 0.1%

(DIAC 2009:43; DIAC 2011:44)

The main focus of the resettlement program in previous decades was that of the Balkan countries but as the chart above indicates, there has been a steady rise in humanitarian entrants from the African nations as a result of on-going conflicts in those countries. The refocus on refugees from Africa, the Middle East and South West Asia has also seen a steady decline in the numbers of European refugees coming to Australia (DIAC 2008).

Asylum Seekers: While the term ‘asylum seekers’ refers to any person whose application for asylum on the grounds of being a refugee is still being processed, the term has come to have a specific connotation in the context of Australia, referring to those people who have managed to reach the shores of Australia by any means other than the formal humanitarian program and have then applied for asylum, to stay on as refugees. The federal government’s own statement of its humanitarian obligations describes its primary obligation as being to the people already in Australia who are found to be refugees according to the Refugee Convention, and only beyond that to the refugees who are overseas (DIAC 2010). In practice however, those applying for refugee status in Australia are treated very differently from those coming through the offshore refugee program, often being incarcerated in detention centres for years. Under the mandatory detention provisions in Australian law, anybody who is an ‘Irregular Maritime Arrival’ and arrives without appropriate documentation is invariably detained (Amnesty 2009). Further, from October 1999 until August 2008, even if their claims were deemed to be genuine, they were given what was called a ‘temporary protection visa’ (TPV) and denied many of the settlement facilities that refugees are provided in Australia (Phillips 2004; DIAC 2009).

The temporary protection visas and the similar temporary humanitarian visas were introduced by the government of the time to ‘discourage people smuggling activities resulting in unauthorized boat arrivals and to discourage refugees leaving their country of first asylum. The evidence clearly shows, however, that TPVs did not have any deterrent effect. Indeed, there was an increase in the number of women and children making dangerous journeys to Australia’ (DIAC 2009). Since 2008, the process has been modified to replace the temporary protection visa with a ‘resolution of status’ (ROS) visa that has all the facilities of a permanent protection visa (DIAC 2009).

I acknowledge that many of the asylum seekers go through the process of forced migration, detention and assessment into the legitimacy of their claims in addition all the issues faced by other refugees. This is further exacerbated by the fact that they are not able to access many of the services to deal with these issues and are subjected to further trauma in the form of detention. As this thesis is focusing on the context of refugees within the settlement services provided by government, asylum seekers who could not access these services have not been included in this study, with the exception of one participant who had entered Australia as an asylum seeker but had subsequently been granted a humanitarian entrant visa and had been able to avail of settlement services accordingly.

The Health of Refugees:

Refugee health has a specific, yet broad, meaning which depends on the context in which it is being used. In the context of the CHEs or complex humanitarian emergencies, it refers to the acute management of the health issues involved in the movements of large sections of the population, and the attendant issues relating to poor hygiene, overcrowding and lack of health infrastructure (WHO 1996; Olness 1998). In terms of resettlement to third countries it refers to the elaborate screening and assessments used for identifying exotic communicable diseases to protect public health (Hale, Wood et al. 2006). And finally, in terms of the post-resettlement period, refugee health refers to the “management of health and health services to control the potential for the marginalization of minority resettled populations, spanning the provision of cultural competencies for health service staff to addressing the specific physical and mental needs of torture and trauma survivors’ (Allotey 2003: xxi-xxii).

The focus of this thesis is on the last area of refugee health, i.e. the post-resettlement phase, though with the clear understanding that many of the issues encountered in this phase have their roots in the pre-resettlement phase. Also, in the context of this thesis, the focus is on those aspects of the health of refugees that may be impacted on by the trauma of the refugee experience.

Refugees face physical hardships, emotional trauma, torture and deprivation, often witnessing disasters, wars and the deaths of immediate family members prior to fleeing (Babacan and Gopalkrishnan 2005; UNHCR 2005; VFST 2007). The trauma they experience is increased by attempts to escape from the situation; a process that

often involves loss of homes, assets and livelihood as well as separation from family and friends (Aroche and Coello 2002). Also, the Complex Humanitarian Emergency (CHE) that may have caused the dislocation and loss is often associated with precipitate epidemics of infectious disease, malnutrition, and starvation, violence and trauma. Loss of life on a large scale is often associated with CHEs (Gushulak and MacPherson 2006; UNHCR 2007). Many refugees also suffer torture, either within state systems or in other, more unregulated situations. The Victorian Foundation for the Survivors of Torture reports that more than 7 out of 10 refugees routinely undergoing health assessments reported having experienced psychological or physical violence of some kind (VFST 2007).

This is further exacerbated in the formal and informal refugee camps that they move to, sometimes in neighboring countries. Refugee camps are often very crowded places, with living conditions strained by the very basic infrastructure available and the number of people needing to use it. Violence can be a part of camp life, with women and children at particular risk in the situation (Aroche and Coello 2002). Food is also an issue with nutritional deficiencies impacting on vulnerable sections of the population. Infectious and other diseases also spread easily in the crowded living conditions (Olness 1998). Security in these situations is particularly a concern for women, children and other vulnerable groups such as people with disabilities (UNHCR 2005). The World Health Organization states that refugee life means that:

- *People may not know what is going to happen to them and have no control over their situation.*
- *There is very little or no employment*
- *There is little space and movement, and not much to eat and drink*
- *Normal roles, cultural life and daily routines have been lost, leaving people uncertain, frustrated and depressed*

Because of this situation parents in the camp may become very dependent....Men lose their means of earning and providing for their families. Women lose their traditional ways of caring for their families and rearing their children. Everyone loses self-respect, motivation and interest in life.

(WHO 1996:66)

Many of these issues and responses beginning with dispossession, life in refugee camps and, for some, detention upon arrival in Australia, make migration patterns and settlement processes for refugees very different from those of other migrants (Brautigam 1996). For many refugees the trials of settlement are all the more difficult and accentuated as they have passed through harrowing times before arrival in the new country (Babacan and Gopalkrishnan 2005).

Aroche and Coello (2002) argue that refugees face three kinds of challenges in their country of resettlement beginning with torture and trauma issues. The trauma experienced in the context of organized violence not only places individuals, families and communities in a vulnerable position in the host country but also interferes with their ability to access and utilize their internal resources to the fullest potential, placing refugees at great disadvantage in negotiating the complex demands of exile, migration and resettlement. Secondly refugees face exile, migration and resettlement issues. Exile and migration include all the security and health issues involved in movement, life in the refugee camps, helplessness and dependence as well as loss of support networks of friends and family. There is also a loss of connection to the external environment as well as the process of coping with this loss of connection as a form of mourning. This also leads to a loss of coherence with the internal map of reality and the external environment, leading to basic issues of identity.

Resettlement also puts a number of stresses on the individual family and community, a phase characterized by the need for a steep learning curve while being impacted on by the diminished personal resources due to their lived experience. And finally refugees also face the normal life cycle stages and personality/ family issues: the refugee experience can make the normal life cycle stages difficult to negotiate, or vice-versa, where the normal life cycle stages may bring up issues related to the refugee experience. All of these issues in turn impact on the health of refugees (Aroche and Coello 2002).

The health problems experienced by refugees have been widely documented. Much of the language used in the literature is placed within the biomedical paradigm, with extensive separation between the so-called mental and physical elements of health and illness and the linear relationships of cause and effect (WHO 1996; Tribe 2005; Feldmann, Bensing et al. 2007; VFST 2007). As noted in the introductory chapter,

the term biomedicine is consistently used throughout this thesis to refer to mainstream medical systems that are based on the natural sciences like biology and physiology (Stedman 2006). I will be arguing in the next chapter that this overwhelming dependence on the biomedical model is not the most effective response to the health issues of refugees. However, given the paucity of scholarly literature documenting the health issues of refugees within a non-biomedical model, I have to use the language of biomedicine to describe the key issues of the health of refugees, especially those related to the trauma of the refugee experience.

Kiesler (1999) points to a number of research studies to state that life stressors of various types place individuals at greater risk for a variety of physical diseases and mental disorders and that psychosocial stressors contribute both formative and precipitative causal influence to the occurrence of mental disorders. In the case of refugees these stressors are in the form of intense trauma often experienced over a lengthy period of time. The psychological effects of trauma tend to be enduring and long-lasting (Silove 1999). Some of these can be classified under cognitive, psychological and neurovegetative symptoms. Cognitive symptoms include disorientation, memory disturbance, impaired reading and poor concentration. Psychological symptoms include anxiety, depression, irritability, aggression, self-isolation and social withdrawal. Neurovegetative symptoms include lack of energy, insomnia, nightmares and sexual dysfunction. The range of problems can include depression, anxiety, guilt, loss of concentration and memory problems and many other issues that are often described as symptoms of posttraumatic stress disorder (PTSD) (Bendfeldt-Zachrisson 1985; Fischman and Ross 1990; Silove, Tarn et al. 1991). Nairn (2005) argues that the cluster of conditions experienced by refugees results in 'Complex PTSD' rather than simple PTSD, which can be more related to a single event. She states that the set of symptom groups observed in complex PTSD more accurately reflects the complex post trauma conditions observed in refugees and asylum seekers. Ater (1998) also raises this issue of Complex PTSD especially in the context of torture survivors.

The incidence of PTSD among refugees is also of concern for two reasons. Over seventy per cent of those suffering from PTSD are symptomatic for at least six months and often for years (Sabin, Cardozo et al. 2003). Secondly, people diagnosed with PTSD have at least one other psychological disorder, with one Australian study

that looked at 10,000 participants, demonstrating that women with PTSD were ‘23 times more likely to develop depression, 10 times more likely to develop generalized anxiety disorder, and 10 times more likely to develop panic disorder’ (Emerson, Sharma et al. 2009:123).

Clinical research in a number of studies demonstrates a high prevalence of posttraumatic stress and depression symptoms among refugees (Hollifield, Warner et al. 2002). Stoller and Krupinsky (1973) found that Jewish refugees displayed high rates of neurotic symptoms associated with their war-time experiences, symptoms that are exacerbated as they got older. Mestrovic (1988) identified a number of conditions among refugees from the former Yugoslavia including schizophrenia, alcohol and drug-induced psychosis, acute stress and depressive disorder. Tan et al. (1986) excavated a number of psychiatric symptoms such as anxiety and depression among approximately 35 per cent of the respondents in study of refugees from Vietnam, Cambodia and Laos. Sabin et al. (2003) found that psychiatric morbidity was highly prevalent in the study population of Guatemalan refugees living in Mexico 20 years after civil conflict, where 11.8 per cent met *DSM- IV* criteria for PTSD, 54.4 per cent had anxiety symptoms and 38.8 per cent had depression symptoms. A similar study of Cambodian refugee households, 20 years after resettlement in the United States, showed high rates of PTSD (62 per cent, weighted) and major depression (51 per cent, weighted). The literature also shows that being of older age, having poor English-speaking proficiency, being unemployed, being retired or disabled and living in poverty also have strong correlations with high rates of PTSD and major depression (Marshall, Schell et al. 2005). The last two studies cited are also useful in that they studied random households among the target population rather than those who are seeking health or social services, who would have more severe issues.

With regards to the commonly detected symptoms of PTSD among refugees, Lin (1986) adds a note of caution that symptomatic behavior of refugees are common psychological reactions to stress and need not necessarily be equated with those of a major mental illness requiring a psychiatric diagnosis. This is further affirmed by Moore (2000) who examined several examples of over-diagnosis of disorders such as schizophrenia and paranoia among specific ethnic groups.

Refugees also deal with a range of physical health issues. A study of general practitioners in Melbourne (Tiong, Patel et al. 2006) revealed that the most common physical health issues that they identified among refugee clients include vitamin and iron deficiencies, schistosomiasis, musculoskeletal problems, gastrointestinal infections, latent tuberculosis, dental problems and skin problems. The general practitioners in this study also identified 19 per cent of the patients as suffering from mental health issues, though this is not a reliable figure without adequate mental health screening. Olness (1998) pointed out a range of physical health issues impacting on the health of refugees, including sexually transmitted disease, parasitic disease, infectious disease, nutritional deficiencies, dental problems, tuberculosis and genetic disease. In the context of the discussion of physical issues of refugees within a Western medical framework, some scholars refer to somatization, or the physical symptoms reflective of mental distress, saying it can be a major part of the presenting symptoms, including chronic complaints such as those of joint or abdominal pain, insomnia, nausea, headaches, sinus and breathing problems, and palpitations (WHO 1996; NCTSN 2005).

The severity of health issues varies across gender and age variables. In presenting their meta-analysis of refugee mental health, Porter and Haslam (2005) state that female refugees in the study had worse mental health outcomes than male refugees. This difference is also pointed out by Babacan and Gopalkrishnan (2005) who argue that refugee women are more vulnerable to settlement and adjustment problems due to poorer English proficiency, limited economic means, traditional family constraints, separation from support systems, unfavorable housing and employment outcomes and social marginalization, all over and above the trauma of racist and sexist violence that they may have already experienced in the process of exile, migration and resettlement. Minas et al. (1988) also reported that Turkish women refugees had high rates of depression and anxiety, with symptoms of insomnia, irritability, suicidal ideas, exacerbated due to social marginalization, cultural adjustment and isolation.

Porter and Haslam (2005) suggest that children and adolescents appear to be less affected by the stresses of displacement as compared to adults. However, this is a relative difference, and refugee children continue to be severely impacted on by mental and physical health issues. Olness (1998) points to a study with Cambodian

refugee children, where 53 per cent had depressive disorders while 50 per cent suffered PTSD by DSM-III (Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association) standards. The White Paper on Child and Adolescent Mental Health (RTTF 2003) draws from numerous research studies to demonstrate the high levels of symptoms seen in refugee children. However, they also caution that the process of conceptualizing refugee children's stress responses from a pathological perspective pathologises the individual, potentially ignoring coping and resilience, in a culturally biased manner, all of which may lead to misdiagnosing, overpathologising, or failing to identify mental health problems in people of other cultures. At the physical level, before and during flight, the issues include high incidence of disease, malnutrition and infections, many of them intrinsic to the living conditions and lack of infrastructure. They also include untreated fractures and other common musculoskeletal injuries, chronic malnourishment as well as infections such as cerebral malaria, meningitis and encephalitis. Many of these issues also have long-term sequelae, both neurologically and psychologically. During resettlement, many of the severe physical issues may have been dealt with, but many of the children continue to present with a host of chronic problems such as ear infections, fungal and parasitic infestations, latent tuberculosis, hepatitis B, anemia, lead poisoning, dental problems and stunting (RTTF 2003).

Many of the physical and mental health issues faced by refugees can be exacerbated by the resettlement experience which, according to the National Population Council (1991), is the process by which an immigrant establishes economic viability and social networks following immigration in order to contribute to, and make full use of, opportunities generally available to the receiving society. In the case of many refugees, this process is fraught with complex issues that can hold them back from fully participating in society and impact on their health (VDHS 2008; RCOA 2010). The Victorian Foundation for the Survivors of Torture describes some of these issues very succinctly in its guide to 'Promoting Refugee Health'.

The early settlement period may be a time when people from refugee backgrounds have limited access to resources known to protect and promote health. They tend to be over-represented among the poor and to experience associated social and economic disadvantage; are concentrated in those

areas of the labour market characterized by poor working conditions and remuneration and job insecurity; experience relatively high rates of both unemployment and underemployment; and are often housed in sub-standard and insecure accommodation. Lack of understanding and in some cases active discrimination and racism in the host community can further serve to undermine their sense of physical security and self-esteem.... The early settlement period is also a time when people may have limited access to family and social support. While many will have lost or become separated from family members in the course of their refugee experiences, cultural and language differences may make it difficult for them to establish connections and secure social support within the receiving society.

(VFST 2007:26)

Several scholars have pointed out that the lives of refugees in Australia are complicated by having to face negative and racist attitudes directed at them as also facing personal and institutional discrimination in the workplace. Despite anti-discrimination legislation, this leads to refugees being relegated to pockets of “niche” employment in the secondary labor market, low income levels, lack of opportunity, and perceptions of discrimination, all of which can have negative impacts on health (Colic-Peisker and Tilbury 2007; VicHealth 2007; Fozdar and Torezani 2008; Babacan, Gopalkrishnan et al. 2009; Correa-Velez, Gifford et al. 2010). Beiser (1991) presents a model on refugee stress as a product of pre and post migration stress as well as personal resources, social resources and socio-demographic characteristics. He further argues that post-migration experience, especially in the first two or three years, has a significant impact on refugees. Some of the challenges relate to their own traumatic experiences and the impact of this on various aspects of their life. Others are associated with the losses and demands associated with exile and the process of migration and settlement in a new country.

This is further backed up by research by Ellis et al. (2008), who report that post-resettlement stress, acculturative stress and perceived discrimination all contribute significantly to the prediction of PTSD symptom severity, even among severely traumatized young people. Further, perceived discrimination was the strongest predictor of depression among their sample population. An international review by

the Victorian Health Promotion Foundation also points out to a strong link between self-reported discrimination and depression and anxiety, a probable link with a range of other mental health and behavioral problems and emerging evidence of a link with poor physical health, such as diabetes, obesity and high blood pressure (VicHealth 2007).

The Refugee Health System in Australia

The combination of the impact of presettlement experiences and resettlement experience places refugees at a profound disadvantage when negotiating the complex demands of living in a new country and living a healthy life. The UNHCR is the primary organization that negotiates the country of resettlement for refugees. Australia, in its role as a resettlement country, has developed a system of health services to deal with the unique needs of refugees. If humanitarian entrants are destined to be resettled in Australia, the Federal Department of Immigration and Citizenship (DIAC) formerly known as the Department of Immigration and Multicultural Affairs, ensures that health checks are carried out by a panel of doctors and specialists nominated by DIAC in the country of departure (Hale, Wood et al. 2006). Humanitarian entrants must satisfy the health requirements as specified under the Migration Regulation, requirements that it could be argued are designed to minimize public health risks to the Australian community while regulating public expenditure on health and community services (Correa-Velez, Gifford et al. 2005). Some of the requirements include a medical examination, tests for Tuberculosis and HIV/AIDS and in some cases, screening for Hepatitis B. The residency visa is only granted after these tests are cleared. Further, since 2005, another set of tests, known as the predeparture screen, are carried out 72 hours before departure as a fitness-to-fly check (Hale, Wood et al. 2006; Smith 2006).

Humanitarian entrants to Australia have the same eligibility for Social Security Benefits, Medicare and Health Care Cards, including the Pharmaceutical Benefits Scheme, as other permanent residents of Australia. Additionally, they are also eligible for the Early Health Assessment and Intervention Program and the Torture/Trauma Services (Correa-Velez, Gifford et al. 2005). Once they arrive in Australia, much of the early screening, assessments and treatments are provided through refugee-specific services such as community or hospital-based clinics and specialized torture and trauma services (Woodland, Burgner et al. 2010). Where these

institutions are not available the services are provided through community general practitioners and mental health practitioners (McDonald, Gifford et al. 2008). Towards this end, in May 2006, the Federal Government introduced a new Medicare item (item 714) to remunerate general practitioners (GPs) for conducting comprehensive health assessments of humanitarian entrants within the first 12 months of arrival in Australia (QH 2008:9). However, there is inadequate take up of the Medicare item 714, varying across the different states and territories (Woodland, Burgner et al. 2010). There is also some evidence to suggest that while the health of refugees is lower than the health of the Australian-born population, levels of hospital utilization by the refugee population are lower or the same as the Australian-born (NCTSN 2005; Correa-Velez, Sundararajan et al. 2007). This suggests that the issues of access facing refugees are not enabling refugees to utilize the health system effectively even though they have significant health problems (NCTSN 2005; Correa-Velez, Sundararajan et al. 2007; Feldmann, Bensing et al. 2007; Fenta, Hyman et al. 2007; Woodland, Burgner et al. 2010).

Refugees are initially settled under the Integrated Humanitarian Settlement Scheme (IHSS) delivered by DIAC through selected service providers. These services, generally provided by Non-Governmental Organizations (NGOs) from 6 months to up to 12 months, involve an assessment of the needs of the entrants and service delivery to meet those needs (DIAC 2009). The services provided under the IHSS include:

***Case Coordination, Information and Referrals**, which includes a case coordination plan based on an initial needs assessment, information about and referral to other service providers and mainstream agencies and help for proposers to fulfill their role of assisting SHP entrants.*

***On Arrival Reception and Assistance**, which includes meeting eligible entrants on arrival, taking them to suitable accommodation, providing initial orientation and meeting any emergency needs for medical attention or clothing and footwear.*

***Accommodation Services**, which helps entrants to find appropriate and affordable accommodation and provides them with basic household goods to start establishing their own household in Australia.*

***Short Term Torture and Trauma Counseling Services**, which provides an assessment of needs, a case plan, referral for torture and trauma counseling and raises awareness among other health care providers of health issues arising from torture and trauma experiences.*

***The Complex Case Support Program**, a relatively new program begun in October 2008, which provides specialized and intensive case management support to humanitarian entrants with special or complex needs that extend beyond the scope of existing settlement and mainstream services. This service can be availed of for up to two years after arrival.*

(DIAC 2009; DIAC 2009)

Once the initial period of six months is over, the humanitarian entrants move into the general settlement services provided through the different migrant service agencies and organizations.

Each State provides a different model to respond to the health needs of refugees, especially during the period of initial settlement. While they all involve specialist refugee health services such as refugee clinics, as well as general hospitals and general practitioners, the methods of interaction between these units vary (QH 2008). Some jurisdictions, like Tasmania and Western Australia use centralized clinics in public hospitals to focus on infectious disease screening (Smith 2006). Queensland uses a hub and spoke model that involves a central unit that interacts with the others in terms of training, capacity building and information provision. New South Wales has the state-funded Refugee Health Service providing clinical services as well as support to mainstream health services. Victoria focuses on GPs to provide health services for refugees by providing support through a network of refugee health nurses (Smith 2006; QH 2008; VDHS 2008; SSWAHS 2009). The models used by the different States are described in detail in Appendix 6.

Besides the health services that cater to the physical health needs of refugees, there are eight specialist torture and trauma services located in each capital city of Australia that support humanitarian entrants in each state. Together they form the network called the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT). These services are funded through the Program of Assistance to Survivors of Torture and Trauma (PASTT), funded by the Commonwealth Department of Health and Ageing (FASSTT 2006) since 1994, with an annual budget of \$4.8 million (DoHA 2010; VFST 2010). The services provided by the different torture and trauma services are presented in Appendix 7.

The framework of practice in refugee health is largely within the dualistic biomedical paradigm (which is discussed at length in chapter 3), involving a clear separation of physical and mental services (DIAC 2008; QH 2008). The physical health elements are catered to by hospitals, clinics and GPs while the mental health issues are managed through non-governmental organizations, psychiatrists and counselors. The notable exceptions are the co-located services in the Australian Capital Territory and South Australia which cater to refugees in the initial phase of settlement (Woodland, Burgner et al. 2010). Given the high levels of co-morbidity, or co-occurrence of several diseases or disorders in the biomedical sense, among refugees across the world, there is a strong argument towards integration of services across the providers of physical and mental health and torture and trauma services (Woodland, Burgner et al. 2010).

The emphasis on the separation of physical and mental health systems in working with the health problems of refugees raises several issues. While it is true that within any refugee population there are those who are severely traumatized and acutely mentally ill, the great majority are experiencing severe distress and suffering, conditions that can be managed using a host of other therapies and systems rather than psychiatry and medicine (WHO 1996; NCTSN 2005). As the World Health Organization states in the context of refugees in conflict and post-conflict situations:

...distress and suffering are not psychiatric illnesses. These reactions are normal (expected) reactions to extraordinary violent events and therefore generalized psychiatric care is inappropriate and must be prevented.

(WHO 2000)

There is also the issue of the cultural appropriateness of biomedical responses to the mental health issues of refugees. While this will be discussed at length in the next chapter, some of the key elements may be mentioned here. Culture affects how different cultural groups, in this case refugees from different cultural contexts, perceive health and illness, adopt health-seeking behavior, and view the efficacy of health modalities, all of which in turn impact on treatment modes and responses to treatment (Lien 1992; Babacan and Gopalkrishnan 2005; Murray and Skull 2005; Fenta, Hyman et al. 2007; Kline and Huff 2007). Culture also modifies the power in the healing relationship and can lead to disempowerment of the refugee seeking help (Blackwell 1993). Further, in many cases, refugees come from environments where the biomedical model is not the only health paradigm, and they may be used to accessing a plurality of health systems such as indigenous medical systems (Lien 1994; WHO 1996; Papadopoulos, Lay et al. 2003; Fenta, Hyman et al. 2007). As such, the predominant biomedical paradigm may be insufficient to respond to the cultural health needs of refugees (WHO 1996; Singer 2008).

The systems of support, especially in the case of mental health issues, also begin to be a major problem after the IHSS stage, as the vast majority of refugees move out of refugee-specific systems that are conscious of their issues and have to go to generic medical practitioners and institutions that are not as well equipped to deal with the complexities that make up refugee health (RCOA 2010). Woodland et al. (2010) point out that the systems are often inadequate in terms of the ability to connect newly arrived refugees with GPs with the necessary interest and expertise, and that considerable investment is required to develop specific expertise in the health of refugees. Some of the problems that GPs face include lack of awareness of what previous screening or treatments refugees had experienced, lack of knowledge of cultural differences as well as history of torture and trauma and its implications and lack of familiarity with the management of the unique conditions of the health of refugees, as well as lack of referral services in many areas (Johnson, Ziersch et al. 2008). The Refugee Nurse System established in Victoria and NSW is sometimes cited as a way to support and educate GPs in their work with refugee clients (VFST 2007; Woodland, Burgner et al. 2010).

The use or lack of use of interpreters is another issue especially in the context of hospitals and GPs who are not focused on the health of refugees (Correa-Velez,

Gifford et al. 2005). Woodland et al. (2010) argue that the use of professional interpreters for newly arrived refugees from non-English speaking backgrounds is a cornerstone of good clinical practice. And yet several scholars have pointed out that the lack of use of interpreters or the use of family members as interpreters continues to be an issue (Correa-Velez, Gifford et al. 2005; Murray and Skull 2005; Johnson, Ziersch et al. 2008; McDonald, Gifford et al. 2008; Sypek, Clugston et al. 2008; RCOA 2010).

The Victorian Government Department of Human Services summarizes some of these issues as:

Newly arrived refugees can often experience difficulties in accessing health and community services in a timely and effective way. Seeking assistance for often complex and multiple health conditions can be very difficult, especially when numerous tests and appointments at a variety of services are required. This is usually exacerbated by a lack of familiarity with.... service systems. In addition, some refugees may find it difficult to prioritize their health against other settlement tasks such as finding housing and employment and schools for their children. Transport difficulties due to large family size, housing location and lack of knowledge of where services are located and how to get there can be significant barriers to access. Psychological conditions associated with torture and trauma may also affect access to services due to lack of self-care, mistrust and anxiety.

(VDHS 2008:20)

Particularly in the non-metropolitan areas of Australia, including the smaller cities and the rural and regional centres, all of these issues are exacerbated by the lack of specialized refugee health services and issues of language accessibility including lack of suitable interpreters and problems with the telephone interpreting services (Sypek, Clugston et al. 2008).

Summary

This chapter provided an exploration of the refugee experience and context globally and nationally. The arrival of refugees to Australia takes place through government migration and humanitarian settlement policies. Australia's settlement policies and

systems are geared towards achieving full economic, social and civic participation among humanitarian entrants along with psychosocial health and wellbeing and yet significant gaps exist towards achieving these goals (Correa-Velez, Gifford et al. 2010). As Aroche and Coello (2002) explain, the environmental factors of traumatic experience, exile, migration and resettlement, and the normal life cycle all interact at a very complex level with the attributes of the individual refugee including their emotional, psychological, cultural, educational and experiential states to determine their health situation. The chapter questioned whether a system that is primarily based on one dominant paradigm, i.e. biomedicine, and is clearly demarcated in terms of how it deals with issues of the body and those of the mind, can respond effectively to the multifactorial and complex issues of the health of refugees. In order to address health issues faced by refugees the biomedicine and complementary and alternative medicines (CAMs) need to be interrogated. The next chapter examines the strengths and weaknesses of the biomedical models and CAMs in relation to the health of refugees.

Chapter 3: The Biomedical Model, CAMs and the Health of Refugees

In this chapter, I explore the key concepts of the different approaches towards health and illness. I examine the biomedical model and its ability to respond to some of the issues that have been presented in the literature including the issues that emerge from the social and cultural environments. I then go on to analyze complementary and alternative medicine systems, their emerging popularity and increasing engagement with scientific frameworks and systems. The contentious relationship between biomedicine and CAMs is then examined and I introduce the concept of Integrative Medicine as a framework within which different systems can work together.

The Biomedical Model

Much of the thinking around health and illness in the Western world up until the middle ages was constructed around religion and God, and the focus on the human soul and its ties to God took away from the study of biology (Sheridan and Radmacher 1992:87-86; Friedman and Adler 2007). Historically, ‘healing in the Western tradition, as in many cultures, was a unitary system with no separation of secular or sacred, or of body, mind and spirit’ (Engebretson 1994: 241). The dramatic changes in human thinking that took place through the renaissance and through the thinking of scholars like Rene Descartes laid the foundation of the science of medical biology and a new model of conceptualizing health and illness, the *biomedical model* (Kiesler 1999; Sarafino 2008) or *biomedicine*. The development of biomedicine is closely intertwined with the development of science and the predominance of the scientific method (Engebretson 1994). This has ensured that the principles of *positivism* and *reductionism* continue to determine the ways in which biomedicine approaches ideas of health and illness. Intrinsic to the positivist approach to biomedicine is the view that empirical experience serves as the basis of all knowledge and that facts as derived through sensory experience and, by extrapolation, data derived from machines and instruments as extensions of that faculty, are universally observable (Sheridan and Radmacher 1992).

There is no doubt that biomedicine has provided a good framework for the alleviation of human ailments. The story of medicine is a story of triumphs of disease

control and prevention (Kiesler 1999). Donald Seldin (1981) describes medicine and the biomedical model as a powerful conceptual system and a body of knowledge about biomedical disturbance. According to him 'medicine is a narrow discipline. It does not promote the realization of happiness, inner tranquility, moral nobility, good citizenship. But it can bring to bear an increasingly powerful conceptual system for that type of human suffering rooted in biomedical disturbances' (Seldin 1981:83). Pellegrino focuses this further in stating that medicine is an activity whose essence appears to lie in the clinical event which demands that scientific and other knowledge be particularized in the lived reality of a particular person, for the purpose of attaining health or curing illness, through the direct manipulation of the body, and in an value-laden decision matrix (Pellegrino 1976:17). Libster (2001:8) also states that what has been developed medically in Western countries is nothing short of miraculous, and yet no health system is perfect for all situations and all people at all times.

Biomedicine has been very successful at shifting the burden of illness from acute infectious disease to chronic, often stress related, degenerative disease, the causes of which are largely a result of personal attitudes and lifestyles (Clark 2000; Libster 2001; Friedman and Adler 2007). Infectious diseases tend to be tied to single causal agents while chronic diseases have multiple behavioral and socio-cultural as well as biological factors (Kiesler 1999; Cohen 2003). In Australia, for example, death rates from infectious diseases dropped from 180 deaths per 1000 in 1921 to about 8 deaths per 1000 in 1996, a dramatic drop which could be ascribed to the advances in biomedicine and public health (Duckett 2004). Consequently, the factors that contribute to risk or confer resistance to chronic illnesses have come to play an important role in determining health outcomes (Dacher 1995; Worthman and Kohrt 2005).

The reductionist focus of the biomedical model is further supported by the rise of evidence-based medicine (EBM) over the last couple of decades (Porta 2004). Sackett et al. (1997) describe EBM as being the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It envisages an effective empirical testing system for all treatments, one that strictly embedded in the scientific method and involves controlled, randomized and double-masked trials, meta-analysis and systematic review (Porta 2004). Jonas

(2002) argues that the dialectic between a reductionist and holistic orientation in research strategies in biology has been an important subtext in biomedicine for the past one hundred years. However, EBM continues to be resisted by physicians who value the patient's experience as well as their own clinical experience (Libster 2001).

Issues with the Biomedical Model

Nettleton and Gustafsson (2002:3) argue that the biomedical model has been the dominant paradigm in Western medicine or, as Libster (2001) states, it is currently the dominant health culture in Western countries, the word 'culture' being used to represent a system of health beliefs and practices. Byron Good (1994) extends this concept even further to argue that medicine, or biomedicine, is the core of the Western soteriological vision, an understanding of the nature of suffering and the means of transforming or transcending it and achieving salvation; a concept that, according to Weber, was what civilizations are organized around. From the perspective of this model, biomedicine is the standard that all other medical systems should aspire to, and not just one medical system among many (Cunningham and Andrews 1997). However biomedicine, with its principles of objectivism and positivism, does not reflect all health systems and beliefs and is in little more than its infancy when compared to rich traditions of healing that have existed in Chinese or Native American health care beliefs and practices (Libster 2001).

Over the years, the biomedical model has come under criticism for a number of reasons (Sarafino 2008). The original challenge to it in the Western world has been the field of psychosomatic medicine, which has been studying the interaction between psychosocial factors of health and disease with the biological factors for over fifty years (Sheridan and Radmacher 1992). Much of the evidence that has appeared from this field substantiates the ideas that the mind is at least as important, if not more, in the determination of health or disease (Sarafino 2008). Thus, while psychiatrists may continue to treat depression and attention deficit disorders primarily through medication, these approaches are increasingly being challenged by both psychosomatic practitioners and the general public, with demands towards broadening the focus from a primarily biological one to include psychological, social and environmental factors (Friedman and Adler 2007). 'The importance of addressing complexity, nonlinearity, and holistic aspects in biology and medicine is

being explored in a number of areas including epidemiology, molecular biology, physiology, clinical medicine and clinical trials' (Jonas 2002:128).

Research and theorizing from the field of psychoneuroimmunology also validates the complex interconnectedness between the body and the mind especially with the discovery of the mediation of the psychic and physiologic systems by the neuropeptide messenger systems. By examining the physiological linkages that explain relationships between psychological factors and the etiology and progression of disease (Kemeny 2007), this area of research points to the critical need for a model of health and illness that incorporates the interconnectedness of the body and the mind. However the concepts of Cartesian dualism still continue to play out (Gaydos 2001), as in the conceptual distinction between 'disease' and 'illness', referring to the objective evidence and the subjective experience, that characterizes contemporary Western biomedicine (Thorne 1993).

Biomedicine can lead to objectification of the patient as 'cases' or 'disease bodies' rather than as unique individuals with particular needs (Germov 2009). Brown (1997) argues that the biomedical model does not respond appropriately to the needs of the individual especially where models of the body other than those presented by Western biomedicine are presented. It can also lead to biological determinism that assumes that a person's biological makeup underpins their health status as well as social and economic status. This can further turn towards victim-blaming, locating the cause and the cure of the disease purely within the individual (Germov 2009:12) while not providing them with the power of healing themselves which is inherent in some other healing systems (Dacher 1995). This can impact in a very negative manner on refugees, whose history of disempowerment, trauma, and loss of support systems can leave them in a very vulnerable position in an alien environment (Ong 1995; NCTSN 2005; Feldmann, Bensing et al. 2007).

The biomedical model of health care practice is unable to respond to the social factors that are implicated in many health problems (Brown 1997). The reductionist approach it takes is problematic as it discards the complex social, environmental and spiritual arenas of human existence and treats the experience of disease as if it is occurring in a social vacuum (Macintyre 2003). The theories of social medicine have examined these issues at some length and analyze three major dimensions of the

health paradigm beginning with the social production and distribution of health and illness, which examines how many diseases arise from social aspects that may not be within the control of the individual, and the distribution of diseases may also be a product of the same (Germov 2009). From the traditional biomedical perspective, with the notable exception of the field of epidemiology, most of these factors are ignored in the process of treating disease in the body or mind. As an example of this, developmental epidemiology has combined the biological and cultural modes of inquiry to identify relationships that were previously unrecognized in the biomedical world, between behavior, development, and health that are embedded in the socioecological fabric of everyday life (Panter-Brick and Worthman 1999).

The second dimension is the social construction of health and illness where the very definitions of health and illness can be social constructions that vary across cultures, politics, and morality and over time. This aspect of health and illness, especially as related to culture, is examined at some length a little later in this chapter.

Third is the social organization of health care which examines the power relationships within and across the health services and how this impacts on the provision of health services (Germov 2009:18). In the context of health policy in Australia, Jenny Lewis (2005) argues that the actors who are influential are predominantly medical trained and working in academia, health bureaucracies and public teaching hospitals. She states that they retain this influence because of their special knowledge and authority, particular form of organization, legally granted occupational monopoly, position at the top of the occupational hierarchy in health, autonomy, and wider cultural authority in defining what makes for health and illness (Lewis 2005). The power relationships that exist within the practice of medicine are also significant in the contest that they are a key element in the social control of populations. As Lopez (2004) argues, biomedicine, along with the mental health, disability and welfare systems, has become a major form of social control, which is frequently embodied and experienced as a lived and ethical morality through the practices of self. 'Among the schemes of knowledge/power regulating individual and social bodies, modern medicine is the prime mover, defining and promoting concepts, categories and authoritative pronouncements on hygiene, health, sexuality, life and death' (Ong 1995:1244).

The social roles adopted by biomedical practitioners and their clients are also an issue, with intrinsic inequities of power stemming from the way the medical systems have been constructed, 'professionalized' and 'medicalised'. In the dominant practice of biomedicine, the patient is viewed from a clinical point of view, one that uses an objective appraisal, technical knowledge and norms of practice to frame a diagnosis and course of treatment. The patient is a passive recipient in this process. The doctor focuses on the organic nature of the disease, separating that from the patient as a person, as is usual in the classic medical dichotomy between the body and the psyche (Gaydos 2001; Mino and Lert 2005). These power differentials have undermined the development of qualities of personal autonomy and responsibility that are essential for both human development and for access to the extended aspects of healing (Dacher 1995; NCTSN 2005). The almost overwhelming control imposed by the technological environment of medical equipment and drugs also adds to the patient's increasing sense of disempowerment (Libster 2001).

Dacher also reflects on the limitations of the biomedical model as:

This model has served us well, but with the progressive urbanization of life accompanied by the industrial and technologic revolutions humankind has seen the development of new and very different adversities, which have resulted in the emergence of a uniquely new category of modern day ailments, particularly stress related diseases, acute and chronic that are directly related to personal attitudes and lifestyle. As a result, the limitations of a medical model that cannot effectively incorporate psychological, psychosocial, or spiritual factors- factors that are at the source of these ailments- has become increasingly evident.

(Dacher 1995:187)

Culture, the Health of Refugees and the Biomedical Model,

The process of forced migration that refugees undergo almost always involves moving between cultures, and the final resettlement involves settling into a culture that is often quite different from their own. This has many implications in terms of the health and illness of refugee populations (NCTSN 2005; Chung, Bemak et al. 2008).

The term ‘culture’ itself is a hotly contested concept and has differing definitions depending on the framework that one is analyzing it from. From a sociological perspective, it can be viewed as the values the members of a given group hold, the norms they follow and the material goods they create (Giddens 1993). It is a dynamic template or framework that is used by a society to view, understand, behave and transmit the information to the next generation (Kline and Huff 2007). It is not a single static entity but is multi-layered and may be influenced by a number of aspects including national, regional, religious, gender class and individual issues among others (Tribe 2005). Culture influences our understanding of health and illness, modes of treatment as well as health-seeking behavior such as attitudes to preventative and curative care, attitudes to providers as well as expectations of the healthcare system (Murray and Skull 2005; VFST 2007). Friedman and Adler (2007:8) point out that:

Throughout the twentieth century, medical sociology and medical anthropology made important contributions to understanding the social nature of illness and the social roles of patients and healers. Studies across cultures, across ethnicities and across social classes made it clear that illness is not simply a biological condition but is inherently social and cultural as well.

When we look at the social construction of health and illness, there is significant evidence to show that culture plays a major role in how we understand health and illness and that there are significant differences in cultural understandings of these (Lien 1992; Babacan and Gopalkrishnan 2005; Feldmann, Bensing et al. 2007; Fenta, Hyman et al. 2007; Helman 2007; Kline and Huff 2007). Research conducted by Feldmann et al. (2007) with Afghan refugees in the Netherlands found that most of the participants made no distinction between what Western medicine refers to as ‘mental’ and ‘physical’ health. Further, an immediate connection seemed to be made between health and ‘autonomy’ in the sense of being able to look after yourself and those who depend on you. These views are also substantiated by research with Ethiopian refugees in the UK which showed that their perception of health were that ‘health is happiness and happiness is health’, where health referred to having harmonious relationships, fulfillment of dreams, not being depressed, stressed or worried and being physically fit and not suffering illness (Papadopoulos, Lay et al.

2003). In this sense, the views of health are very close to the World Health Organization's view of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1948).

The causes of disease can be viewed differently across cultures, such as due to possession by ancestral spirits, imbalance between *yin* and *yang* in traditional Chinese medicine, imbalance between Vata, Pitta and Kapha in Ayurveda, failure to be in harmony with nature, the 'evil eye', being out of balance, and breaking of taboos (Lien 1992; Papadopoulos, Lay et al. 2003; Culhane-Pera, Her et al. 2007; Fenta, Hyman et al. 2007; Kline and Huff 2007). This plurality of views of health is supported by Helman (2007) who presents a model of illness causality that ranges across from the individual, the natural world, the social world and argues that every illness has multiple causes and every cultural group would perceive these differently. Many Western approaches tend to be 'predicated on a model that focuses on individual intrapsychic experience or individual pathology, while other traditions may be based more on community or familial processes' (Tribe 2005:8).

These barriers to effective healing may also be impacted on by the power relationship between the cultures of the therapist and the patient. While culture performs an integrative function, bringing together people within a group, it also excludes people who do not adhere to these norms and values. In the context of health systems, this exclusionary aspect of culture begins to play a very significant role in the experience of ill health as well as in treatment especially given a history of power differentials and ideologies that are part of the colonization process in many countries. Ahmed and Bradby (2007) argue in the context of the health and care needs of minority ethnic groups in Britain, that the pseudoscientific notions of biological 'races' and cultural stereotypes of superiority and inferiority continue to create situations of loss of power for some groups while absolving powerful groups and states from responsibility.

As Blackwell (1993:733) states

It is all too easy to repeat the colonising process by imposing a therapeutic ideology rooted in the culture of the host community, giving meaning to the survivors' experience in the language and symbols of that host community

and its professionals, and failing to recognize the rich sources of meaning and symbolism available to the survivor from his or her own culture.

An example may be taken of the issues of refugee mental health where as Aroche and Coello observe, ‘culture is both the cause of this pain as well as the pathway to recovery’ (2004:55). On the one hand, the patient’s attitude towards his/her illness is built around a conglomeration of ethno cultural beliefs and values, personal beliefs, values and behaviors and an understanding of biomedical concepts (Pachter 1994). This then interacts with the therapist’s culture within the clinical encounter. In Australia, as with many other industrially developed countries, most therapists, including those who work with refugees, espouse Western systems of therapy (Wilson and Drozdek 2004; NCTSN 2005) that have evolved within the political contexts in Western countries, often within a colonial framework. In the context of working across cultures, this background involves the therapist dealing with some of his or her own assumptions and resultant behaviors before a helping relationship can be established. Many of the assumptions around normality and psychopathology that are core to Western therapy are culturally embedded in Western, middleclass constructions and have questionable cross-cultural generalizability (NCTSN 2005). Cultural bias and stereotyping can impact negatively on the therapeutic relationship and process. As Kline and Huff (2007:7) argue, cultural differences present major barriers to effective health care interventions especially when ‘health practitioners overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those who might be viewed as different from them in their assessment, intervention, and evaluation-planning processes’.

Culture also impacts on how therapies and treatments are viewed. Stephen Kidson (1993:39) cites a Vietnamese health worker who, in her experience, believes that many Vietnamese refugees see psychiatry/psychology as ‘rubbish’ and that talking and using tablets are of no use for their complaints. This view is not uncommon as ‘talking about painful events may not be experienced as valuable or therapeutic by refugees from societies in which psychological models are not hegemonic’ (NCTSN 2005:32). Sypek et al. (2008) also reflect on several cases where differences of perception of treatment between refugees and GPs in rural and regional towns lead to a mismatch of expectations, and attendant conflict.

In the biomedical systems in place to work with the issues of refugees in countries like Australia and the United States, there is an emerging understanding of many of the culturally different approaches to health and illness (Ong 1995; Singer 2008). The accommodation of these, however, is mainly in the form of reading the symptoms and using the patient's cultural beliefs to present universalized states of biomedicine as:

[b]y controlling the medical terms and practices, and seeking to instill them in patients, academic and medical workers are part of an overall scheme of power that defines the form and content of refugee illness and well-being, while producing the truth-effects that shape the subjectivities of Southeast Asian immigrants. Overworked and under-funded clinics, swamped with clients from all over the world, seek an efficient, though unsatisfactory, strategy to reduce the multicultural and personal details of patients' illnesses into diagnostic categories, so that they can dispense drug treatment.

(Ong 1995:1247)

The literature suggests that the more health services are sensitive to their clients' cultural and linguistic backgrounds, the better are the chances of improved access and equity, health literacy, communication, patient safety and quality of service provision as well as improved health encounters and outcomes through building trust and ensuring follow up (Lamb and Cunningham 2003; Murray and Skull 2003; Smith 2006; Woodland, Burgner et al. 2010). The formal health services, especially those that provide biomedical services after the initial settlement period of six months, continue to be accessed at a relatively low level by refugees (Correa-Velez, Sundararajan et al. 2007; Fenta, Hyman et al. 2007). Both hospitals and general practitioners can prove to be major hurdles for refugees in accessing health services if they are not culturally relevant and working through a multiplicity of approaches while dealing with the health of refugees (Tribe 2005; Correa-Velez, Sundararajan et al. 2007; Feldmann, Bensing et al. 2007; Woodland, Burgner et al. 2010).

The biomedical paradigm presents us with a range of issues in terms of the health of refugees; issues involving the understanding of health and illness, causality and healing, issues of the mind/body duality, reductionism and lack of complexity, power relationships and structures, all of which indicate the need for a framework that

better accommodates difference (Morris, Silove et al. 1993; Silove 1999; Aroche and Coello 2004; Helman 2007; Singer 2008). Scholars have suggested that holistic approaches that address all the needs of refugees – physical, mental, spiritual, environmental and social-cultural, incorporating a multiplicity of systems that include community-based health systems as well as other interventions like art, drama, music and complementary and alternative therapies would be culturally appropriate as well as providing choice to refugees (Papadopoulos, Lay et al. 2003; NCTSN 2005; Tribe 2005; Woodland, Burgner et al. 2010).

Complementary and Alternative Medicine (CAM)

Countries of the West, such as the United States and Australia, have a multiplicity of medical systems besides biomedicine, and these different systems have played a key role for much of their history, at least until the end of the nineteenth century. In the United States, the knowledge held by and the work done by homeopaths, folk healers and other alternative practitioners to the biomedical model were considered authoritative and legitimate until the beginning of the twentieth century (Steuter 2002; WHCCAMP 2002). The Flexner report of 1910 laid the foundation of a transformation of the processes of research and training and lead to licensing arrangements that delegitimized and marginalized all health professionals other than those who followed the biomedical framework (WHCCAMP 2002; Singer 2008). Over the years since then, biomedicine has placed itself at the centre of a no-go zone, drawing out the boundaries that determine who or what is legitimate (Shuval 2006).

While biomedicine has remained the dominant paradigm in the 20th and 21st Centuries, many of the other medical systems, often referred to as Complementary and Alternative Medicine (CAM), have seen a resurgence in terms of their popularity and usage (Bodeker 2007). In Australia, for example, a national survey conducted by the Royal Melbourne Institute of Technology's (RMIT) Chinese Medical Research Group, in collaboration with La Trobe University, found 17 different Complementary and Alternative Medicine systems used widely in Australia, with differing popularity across different States. Further, they also identified that 14 of these, while unregulated, showed equal usage to those that were regulated (Xue, Zhang et al. 2006). This plurality of medical systems is a way of life in many countries across the world, involving both indigenous medical systems as well as other complementary systems that have moved across borders (WHO 2005).

Complementary and alternative medicine, in the context of the Western world, can be viewed as an ‘aspect of cultural diversity in modern ... life, whether found in the ethnomedicine of a newly immigrated group or the widespread CAM utilization of middle-class [people]’ (Hufford 2002:12). Most of the definitions popularly used for CAM have been embedded in its supposed attributes i.e. its untested nature, its foreign origins or its unscientific rationale (WHCCAMP 2002; Wolpe 2002). Many of these terms used to describe these systems are ideological constructs that place negative connotations on the therapies in relation to the ‘scientific, rational world’ of biomedicine (Ernst 2002). The following definition moves beyond these to place the discussion in the arena of historical power relations.

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health care systems, modalities, and practices and their accompanying theories and beliefs other than those intrinsic to the politically dominant health care of a particular society or culture in a given historic period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed.

(OAM 1997 cited in Kopelman 2002:37)

Depending on the country and the time in its history, dominant healing systems can become CAM and vice versa (WHCCAMP 2002). Cohen (2003) views conventional and complementary therapies as being merely complementary aspects of medicine, with one focusing on illness while the other on wellness. The Australian Medical Association (2002) uses the term ‘Complementary Medicine’ to refer to both complementary medicines such as herbal medicines, as well as complementary therapies such as acupuncture and yoga. There is not one single template on which CAM approaches can be placed as they vary significantly in a number of ways. Griffin Trotter (2000) looks at them in the ways that they diverge from the predominant biomedical model.

At the proximate end of the spectrum are the most successful forms of alternative medicine- those fashioned more or less on the lines of biomedicine. Chiropractic, herbal medicine, therapeutic touch, massage

therapy and many other alternative or complementary practices occupy this category. These disciplines are practiced by appointment, in well-lit offices. Practitioners tend to the patient's body as if all the elements of illness were harbored within its boundaries. These approaches depart from mainstream biomedicine by focusing more concertedly on the connection between mind and body. In this sense they offer a more "holistic" account of illness.

(2000: 63)

He goes on to use the term 'alternative medical traditions' to designate health care practices that derive from cultural beliefs and standards that are radically at odds with the beliefs and standards that characterize biomedicine. Some examples of the traditions that are very different from biomedicine, he suggests, are the Navaho (Native American) and the Chinese health care traditions (Trotter 2000).

The National Centre for Complementary and Alternative Medicine in the United States, a government agency that explores CAMs in the context of science, rigorous research, training and information dissemination, has developed a widely used classification that organizes CAMs into five major groups with some overlap.

Table 3.1: Classification of CAM Systems

Major Domains of each CAM	Examples under each domain
Whole Medical Systems/Alternative Health Care Systems: These cut across more than one of the other groups	Traditional Chinese Medicine; Ayurveda; Homeopathy; Naturopathy; Chiropractic; Native American Medicine.
Mind-Body Medicine, taking a holistic approach to health that explores the connection between the mind, body and spirit.	Yoga; Meditation; Music therapy; Dance therapy; Hypnosis; Prayer and Mental Healing.
Biologically based Practices: use substances found in nature such as herbs, foods vitamins and other natural substances.	Herbal therapies; special diets such as macrobiotics; Orthomolecular medicine such as megavitamin therapy; Individual biological therapies such as shark cartilage or bee pollen.
Manipulative and body-based practices	Massage; Feldenkrais; Alexander Technique.
Energy Medicine: Biofield therapies intended to influence energy fields of the body	Qigong; Reiki; Therapeutic touch.
Energy Medicine: Bioelectromagnetic-based therapies using verifiable electromagnetic fields.	Magnet therapy

(WHCCAMP 2002; NCCAM 2010)

CAMs and Health

There are several key areas in which CAMs differ from traditional biomedical approaches in dealing with health issues, differences that often provide the reasons why people resort to CAMs for treatment. Firstly, biomedicine works within a framework of cause and effect, a linear process of pathogen-illness and treatment. CAM practitioners, on the other hand, largely view the patient and the 'illness' from a holistic point of view not restricted to an external pathogen (Jonas and Levin 1999; Guinn 2001; Shuval 2006). This entails looking at the different areas that impact on the health and illness of the person including the body, the psychosocial, the environmental and the social-cultural (Libster 2001). They are often able to provide support, care and healing for those with chronic illnesses, even those where the causes cannot be pinpointed, because of this holistic approach (Jonas and Levin 1999).

The second area is that of power relationships developed in the process. In biomedicine, the doctor retains power, using different tools to fix the illness in the patient. The patient is only a biological machine to be acted upon (Gaydos 2001; Mino and Lert 2005). While CAM practitioners are also experts in their own fields, they tend to act within a more equal, power-sharing relationship, enabling the patients to be active within their own healing process (Gaydos 2001; Guinn 2001; Shuval 2006). Also, most CAM approaches adopt the view that the relationship of the practitioner and the patient is central to a positive outcome (Gaydos 2001). To people who are looking for a sustained healing partnership rather than a brief consultation, as well as self-empowerment, CAMs are increasingly providing a viable alternative to biomedicine (WHCCAMP 2002; VFST 2007).

The third area is where the biomedical practitioners tend to work within an illness paradigm, where the doctor is either treating illness or trying to avoid it in some form. CAM practitioners on the other hand tend to be more focused on nurturing the health of the patient, treating health as the norm, and health enhancement as the goal, being proactive in addressing lifestyle factors and early warning signs (Gaydos 2001; Guinn 2001). Alternative therapies such as Yoga and Tai Chi, among others, enable a more holistic approach to health as more than 'being ill'. They examine five major areas of health enhancement; a) stress management; b) spirituality and meaning

issues; c) dietary and nutritional counseling; d) exercise and fitness; and e) addiction or habit management (Jonas and Levin 1999). This view is supported by Cohen (2003) who suggests that conventional Western medicine appears to concentrate on moving people across from the division between ill health to average health, while complementary medicine seems to concentrate on moving people across the division between average levels of health to enhanced health.

CAM therapies also enable room for traditional, spiritual and cultural practices (Jonas and Levin 1999). Illness, mental or physical, is only one part of a larger cultural schema that explains important moral and social questions. Non biomedical theories of illness locate human affliction more broadly in the relationships between human beings, between humans and non-human beings, and with the moral and cosmic order (Reid and Trompf 1990). The theoretical and philosophical foundations of CAM therapies support integration of the body, mind and spirit and view the person within social and cultural contexts (Gaydos 2001). Many refugees in Australia come from countries that have a tradition of indigenous medicine, and the ability to access similar traditions in Australia can provide affirmation and empowerment, as well as acting as a bridge between the two cultures (Ater 1998; Papadopoulos, Lay et al. 2003). Many refugees are used to working with a plurality of healing modalities including biomedicine in their home countries, and the dominance of the biomedicine within the formal health structures that they face in Australia may be inadequate to deal with their complex health issues (Lien 1994; WHO 1996; Papadopoulos, Lay et al. 2003; Culhane-Pera, Her et al. 2007; Fenta, Hyman et al. 2007).

CAMs involving meditation, massage and relaxation can provide a gentle non-invasive way of dealing with some of the symptoms of trauma such as chronic pain, breathing difficulties, anxiety, depression and stress, and the tactile elements can help to build trust in touch, an element very important to survivors of trauma (FASSTT 2006; VFST 2007). Others such as nonverbal expressive therapies have an important place in treating victims of trauma, such as refugees and survivors of child abuse, since they are especially designed to engage with implicit consciousness and implicit memories. Art, music, yoga and movement therapies have added advantages when therapist and patient do not share a common spoken language (Wilson and Drozdek 2004; FASSTT 2006).

With the increasing vision of an ageing population in countries like the United States and Australia, with the attendant increase in chronic illness, CAMs that work across all these areas have become more important to help to reduce stress and suffering. It is not coincidence that the availability and popularity of CAMs has steeply escalated with the increase of chronic illnesses and the rising health costs (WHCCAMP 2002; Baer 2007) as CAMs are a relatively low-cost way to respond to consumer demand (Wolpe 2002; Baer 2007).

There is a widespread assumption that biomedicine is based on scientific evidence while CAM practices are questionable in the context of rigorous evidence-based research. Guinn (2001) claims that this assumption is fallacious, quoting from the Federal Office of Technology Assessment to demonstrate that up to 80 per cent of therapies involved in the clinical practice of biomedicine have not been proved by rigorous scientific means, a fact placing them on par with CAM practices (Congress 1994). Further, research with medical nurses as well as with doctors who also practice alternative therapies has indicated that many biomedical practitioners have adopted a pragmatic view that if it works it is acceptable, even if the causative process is not clear from a biomedical perspective (Shuval and Mizrachi 2004; Shuval 2006:1793).

Cohen (2003) points out that the practice of holistic health has been very difficult to achieve as many of the established social structures involved in delivering health care do not always foster a holistic approach. He further reiterates that, at the moment, conventional medicine and complementary medicine function like two independent health care systems, in parallel without much interaction (2003). Peters et al. (2002) agree with this stating that, until recently, complementary and conventional medicine behaved like two different cultures, kept apart by radically different languages and theories, and that even today, despite an apparent convergence, each culture tends to see the other as foreign. Adler (2002:413) refutes this, arguing biomedical and alternative health traditions only appear to be irreconcilable, and that 'their apparent inconsistencies are not viewed as such or are deemed insignificant by those who engage in them, either concurrently or sequentially'. Many of these 'irreconcilable differences' are often of emphasis, as for example in the emphasis on technological/surgical/pharmacological solutions in biomedicine as against the underemphasized areas of prevention and wellness

promotion which relate easily to the prevention and lifestyle modification emphasis of many CAMS (WHCCAMP 2002).

In terms of the health of refugees in Australia, a significant number of specialized agencies that work specifically with the survivors of torture and trauma (almost all refugees) utilize a multilevel approach involving biomedicine, counseling and including complementary medicine and therapy. While the PASTT program is primarily funded to work with the mental health issues of refugees using biomedical practitioners and counselors, many of the state bodies have incorporated complementary and alternative medicines as part of their services. Table 3.2 presents the details of the CAM services that are being, or have been provided to refugee groups by the trauma services across Australia.

Table 3.2: Provision of CAM therapies in Trauma Services in Australia

State	Organization	CAMs and related activities
Victoria	The Victorian Foundation for the Survivors of Torture (Foundation House)	Yoga, massage therapy, herbal medicine.
New South Wales (NSW)	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)	Yoga, acupuncture, neurofeedback, activity groups for exercise, crafts, support, psychoeducation and therapeutic groups.
Queensland	Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)	Nutrition therapy, herbal medicine, homeopathy, yoga, massage, aromatherapy and flower essences
Northern Territory	Torture and Trauma Survivors Service of the Northern Territories (Melaleuca Refugee Centre)	Narrative therapies, play therapy, creative arts therapy and dance movement therapy.
Western Australia	Association for Services to Torture and Trauma Survivors (ASeTTS)	Massage therapy
South Australia	Survivors of Torture and Trauma Assistance and Rehabilitation service (STTARS)	Remedial massage
Australian Capital Territory	Companion House (Assisting Survivors of Torture and Trauma)	Bowen therapy and Bach flower remedies.
Tasmania	Phoenix Centre	Massage therapy, relaxation exercises, reflexology, medicinal herbal teas and lifestyle/nutritional advice.

(FASSTT 2006; QPASTT 2006; DIAC 2008; VFST 2010)

Anecdotally, the level of government funding for the alternative services is minimal or non-existent, with money often being used from core funds or sponsorships by corporate entities (Chand cited in Roxon 2007). One NGO refers to the paucity of funding by stating that its natural therapies program is limited and only available to those of their clients most in need of them (QPASTT 2006) a point that is emphasized by the fact that their Natural Therapies program was discontinued prior to their 2009 annual report (QPASTT 2009).

Utilization of CAMs

There is a body of evidence that demonstrates the increasing utilization of medical plurality and CAM across the world as presented in this table:

Table 3.3: Utilization of Complementary and Alternative Medicine (CAM) Systems

Country	Utilization (percentage of population) ¹	Country	Utilization(percentage of population) ¹
Australia	48	France	49
Canada	70	Germany	75
Chile	71	Israel	9.8
China	40	Pakistan	58
Colombia	40	United Kingdom	47
Denmark	33	United States	62/36 ²

¹The survey years in each country varies from 1994 to 2002 depending on the source of the data

²62 per cent included prayer for health reasons: 36 per cent when prayer was excluded

(Eisenberg. 1998; Shuval and Mizrachi 2004; Bodeker 2007; Shaikh, Malik et al. 2009)

Complementary therapies have also become accepted among biomedical practitioners, with over 80 per cent of the GPs surveyed in one research project indicating that they have referred patients for a complementary therapy at least a few times a year (Cohen, Penman et al. 2006) while another survey of 300 family physicians in New England found 90 per cent considered complementary therapies legitimate and most respondents desired training in complementary therapies themselves (Clark 2000:6). Shuval and Mizrachi (2004) also report that 42 per cent to 60 per cent of medical practitioners in Israel refer patients to CAM practitioners. A comprehensive review of 25 surveys of physicians and their practices and beliefs

around five CAM practices found that half the surveyed physicians believed that these practices were useful or efficacious (Astin, Marie et al. 1998). Even the Australian Medical Association (2002) uses carefully worded phrases to acknowledge the growing recognition of the effectiveness of CAMs and concluding by recognizing that evidence-based aspects of Complementary Medicine are part of the repertoire of patient care and may have a role in mainstream medical practice. David Hufford reflects on the irony of this in the context of migrants and refugees, saying:

Physicians are urged to be respectfully aware of the “ethnocultural health beliefs and behaviors”- the CAM beliefs and practices- of the least-assimilated members of immigrant groups, assuming that with time these patients will become “more like mainstream patients”. At the same time, their colleagues are documenting the widespread use of CAM among “mainstream patients”.

(2002:27)

The wide spread use of CAM systems across the world is also being supported by increasing convergence with Western scientific frameworks as evidenced by the number of international peer-reviewed specialist journals on complementary and alternative therapies publishing research studies that are based within the scientific paradigm (Peters, Chaitow et al. 2002). Universities in countries like the UK, USA, Canada and Australia are increasingly incorporating the teaching of complementary medicine in undergraduate medical courses as well providing degree programs in CAM (Peters, Chaitow et al. 2002; Cohen 2003).

The process of mainstreaming is also visible in government recommendations, such as the U.S. Surgeon-General’s Task Force on Pain Management, towards the integration of complementary therapies with biomedicine (PMTF 2010) as well as governments setting up formal governing bodies to regulate the administration of CAM. Some examples of these from across the world include the Office of Complementary Medicine within the Therapeutic Drugs Administration in Australia (Cohen 2003; TGA 2010), the Department of AYUSH that regulates Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy in India, the National Office of TM/CAM in South Africa, the National Institute of Traditional Medicine in Peru,

the Islamic Medicine Centre in Kuwait, and the Department of Traditional Medicine in Bulgaria (WHO 2005).

Government support can be seen in the establishment of government supported research and training organizations such as NCCAM in the United States and the Foundation for Integrated Medicine in the United Kingdom and the National Institute of Complementary Medicine (NICM) in Australia (Peters, Chaitow et al. 2002; NICM 2010). In Australia there are several Centres focused on CAM research and training such as the Australian Centre for Complementary Medicine at the University of Queensland and at Southern Cross University, the Herbal Medicines Research and Education Centre at the University of Sydney and the Centre for Complementary Medicine Research at the University of Western Sydney (Baer 2007).

Increasing acceptance is also substantiated by the fact that many biomedical practitioners are offering CAM therapies as part of their practices, with some UK surveys showing that as much as 60 per cent of UK GPs either providing CAM therapies themselves or employing nurses who deliver them, or delegating treatment to CAM therapists within the practice or elsewhere (Peters, Chaitow et al. 2002). Hollenberg (2006:738-739) refers to this as biomedical appropriation of therapeutic skills from less powerful CAM groups in order to extend the sphere of competence of biomedical practice to areas where others once were. Also worthy of note is the support of CAM therapies by private health insurance companies, which, in Australia, has meant partial subsidization of CAM costs by the federal government in the form of private health insurance rebates (Cohen 2003)

Integrative Medicine

Given the power structures that support the theory and practice of biomedicine to the detriment of other healing systems it is quite clear that an emphasis on medical pluralism or tolerance of other healing modalities does not offer a straightforward solution to dichotomous polarization (Ernst 2002). Some of the issues that would need to be addressed include power relationships such as those between practitioners and patients, as well as those between practitioners of different healing systems. The power dimensions have to be examined, not just from the traditional viewpoint of challenging the dominance of Western systems, but also from the point of power systems and relationships within and across the different CAM systems (Ernst 2002).

Other issues relate to the different paradigms espoused by the different healing modalities and the clash between them, the need for ethical standards of practice, ensuring safety of the patient as well as providing the optimum environment to enable the patient's right to choose a modality. And finally there is the need for a scientific evidence base for CAMs, in an environment where historically the funding has been dramatically insufficient (Gaydos 2001; Peters, Chaitow et al. 2002; Cohen 2003; Lemley 2010). It is in this context that the concept of *integrative medicine* (also called integrated medicine) can play a significant role as a system within which the many healing modalities can work with and support each other in providing the best possible outcomes to patients (Libster 2001; Adler 2002; Cohen 2003; Lemley 2010).

The NCCAM suggests that integrative medicine is a practice that combines both conventional and CAM treatments for which there is evidence of safety and effectiveness (NCCAM 2010). The Australasian Integrative Medicine Association (AIMA) states that integrative medicine refers to the blending of conventional and natural/complementary medicines and/or therapies along with lifestyle interventions and a holistic approach – taking into account the physical, psychological, social and spiritual wellbeing of the person – with the aim of using the most appropriate, safe and evidence-based modality(ies) available (AIMA 2009). It can also be viewed as:

[S]panning the biases of disciplines and cultures, taking a systems approach to the treatment of the patient as well as the physical disorder. It stresses prevention, self-care and establishing healing partnerships. Practitioners in every field are beginning to integrate allopathic (biomedical), behavioral medicine and alternative practices into their treatment protocols.

(The International Conference on Integrative Medicine, cited in Libster 2001:36)

While maintaining the key component of the combination of traditions, Libster goes further to argue that integrative practice is the creation of evolving, healing relationships with patients. The key components of this that she stresses are balance, keen observation and holism and the use of biomedical and caring skills in a creative way that addresses the individual needs of patients (Libster 2001:26). Understanding the need for restoration of balance or equilibrium by assisting the body's natural

quest is the first component. Intelligent use of technologies drawn from different therapies, especially by supporting a patient's right to choose and utilize any modality for healing, can enable the patient to restore their own sense of balance and harmony within themselves and within their environment. One example of this is conscious breathing, where research has demonstrated that pain can be diminished through alteration of breathing patterns (Pert 1997). Using an integrated, holistic approach, practitioners from different healing modalities can simultaneously work to target different domains that impact on refugees (NCTSN 2005; VFST 2007). After all, as suggested by Phelps and Hassed (2011:3), medical practitioners themselves, say:

...just as GPs work in partnership with other medical specialties, so we can work more effectively with appropriately qualified complementary and alternative healthcare providers.

In a quite unique way, the field of nursing appears to be more open to the prospect of integrated approaches that bring different therapies together in practice. Nurses have historically used these modalities in practice and there is a recognition of the need for an understanding as to how they can be developed as part of nursing practice in the new millennium (Libster 2001; Eliopoulos 2004). Nursing theories have established a more holistic base than the medical mode and nurses have less of a theoretical clash with alternative models of healing than biomedical practitioners (Engebretson 1994; WHCCAMP 2002; Shuval 2006). Shuval (2006:1787) also suggests that this could be due to training which includes the social sciences, notions of holism, integration of mind and body, patient-centred practice and empowerment and community orientation, all of which are congruent with CAM practice. However, nurses face this clash when they work in hospitals or institutions that are powerfully rooted in the culture of science and technology (Engebretson 1994:248).

Principles and Practice of Integrative Medicine

As Integrative Medicine is a relatively new area, the principles continue to evolve and change. However, there appear to be some principles that are shared across the statements of many of the experts in this area and I draw on these to enunciate some of the common principles. Most of these focus on those aspects of modern human health delivery where the different healing modalities, especially biomedicine, have

been most criticized. They focus on transforming power relationships, on all aspects of health including the psychosocial and the environmental, attitudes towards health and healing, the paucity of scientific evidence in the case of many CAMs, as well as the dualistic approaches towards the body and the mind (PMTF 2010). These principles can help guide advocacy for policy change as well as the formation of structures such as integrative medicine clinics that provide a new form of holistic health care (Peters, Chaitow et al. 2002).

The White House Commission on Complementary and Alternative Medicine Policy states that one of the core principles of Integrative Medicine is that of *Partnership* where good health care requires teamwork among patients, health care practitioners (conventional and CAM), and researchers committed to creating optimal healing environments and to respecting the diversity of all health care traditions (WHCCAMP 2002:3). This principle is affirmed by Dr. Weil, one of the pioneers of Integrative Medicine, who argues that partnership between the patient and the practitioner is crucial to an integrative practice (Lemley 2010) a view shared by Victor Sierpina (2001). In the context of the partnership between practitioners of different healing modalities, Peters et al. (2002) stipulate that the integration exercise calls for an ability to reflect honestly on the concepts and methods of one's own particular discipline while learning to appreciate the views and methods of others who see the world differently.

The Pain Management Task Force (PMTF 2010) commissioned by the U. S. Army Surgeon-General extends the principle of partnership to one that is *Patient-centred*, where the patient is the leader of a team, and all the health professionals act as consultants and guides. They elaborate on this further in terms of focusing on the importance of self in Integrative Medicine: self-care, self-responsibility, and self-awareness (2010:43), focusing on encouragement of personal responsibility for health (Sierpina 2001). This also involves an emphasis on *Health promotion*, self-care and early intervention for maintaining and promoting health is also central to the practice of integrative medicine (WHCCAMP 2002). This may entail using different healing modalities to facilitate the body's innate healing response (Lemley 2010). In the context of their study of integrative medicine clinics in Australia Grace and Higgs (2010:8) agree with this concept of patient centeredness, stating that the traditional role of the practitioner had changed from the sole possessor of expertise to

‘one among a number of resources that informed clients used when designing personal health care plans of negotiating health care with practitioners’. They conclude that clients did not bring an expectation of being given a prescriptive treatment regime, but rather viewed consultations as opportunities to gather information, advice and for monitoring health.

Another principle central to the practice of Integrative medicine is that of *Wholeness* in health care delivery. Health is viewed here as involving ‘all aspects of life-mind, body spirit, and environment- and high-quality health care must support care of the whole person’ (WHCCAMP 2002:3). All the factors that influence health, wellness and disease including mind, spirit and community as well as body need to be considered in this practice (Lemley 2010). This principle addresses issues around the social production and distribution of health and disease as well as the social construction of health and illness and many of the issues related to health and culture such as differences in values and ethnocultural beliefs (Aroche and Coello 2004; Germov 2009)

Evidence of safety and efficacy is another core principle cited by several experts. The most common criticism of CAMs from the scientific and biomedical establishment is the lack of ‘high-quality’ scientific research and evidence to help identify safe and effective CAM therapies (AMA 2002; WHCCAMP 2002). Lemley (2010) and Sierpina (2001) argue that good medicine should have a reliance on evidence-based scientific thinking when integrating biomedical and CAM therapies. However, this principle is a strongly contested one as there is also significant resistance to the acceptance of scientific ‘evidence’ as the basis of adoption of healing modalities (Gaydos 2001; Peters, Chaitow et al. 2002; Shuval and Mizrachi 2004). Some of the issues with the utilization of evidence-based principles are presented a little later in this section.

While the concept of partnership between the different healing modalities is often cited as central to the integrative medicine paradigm (Peters, Chaitow et al. 2002; WHCCAMP 2002; NCTSN 2005; VFST 2007; Lemley 2010), the predominance of the biomedical paradigm is likely to involve issues with the loss of the power and control that biomedical practitioners would experience within a partnership. This aspect is explored to some extent in a study by Ben-Arye (2010) looking at the views

of dual-trained conventional/complementary physicians as mediators of integration in primary care. The author concludes that there are two distinct points of view in the situation where dual-trained physicians, as well as primary care physicians, envision a 'dominant and leading role of physicians in physician-practitioner teamwork, while non-MD CAM practitioners support a co-directed role' (2010:489). Adams (2003) also noted in interviewing general practitioners practicing CAM that they regarded their incorporation of CAM therapies as 'complementary', while they regarded CAM practitioners as 'alternative' and deficient in their approaches. This difference of views is one that will have to be worked through if integrative medicine is to work in the way that many of its proponents envision.

While these principles as well as the other definitions of integrative medicine point to a number of ways in which teams of practitioners could work together towards providing the best possible care for the patient, there is some emphasis on science and the importance of evidence-based modalities as providing the guidelines as to what is safe and effective. While this seems fair and reasonable in theory, this would have several issues in practice, especially in the context of working with refugees:

1. The lack of funding available for researching many CAMS that do not necessarily bring in money to pharmaceutical companies. An example of this is acupuncture, where the production of needles is a minimal profit source. The issue of funding is also raised by the WHCCAMP final report which recommends that sustained and adequate funding is essential to determine the benefits and limitations of CAM modalities, many of which are widely used already, as also for building and maintaining a strong infrastructure for training skilled CAM researchers and conducting rigorous research (WHCCAMP 2002).
2. The comparatively new area of scientific CAM research which does not yet have the general acceptance of university departments, statisticians, large databases and full time research staff (Peters, Chaitow et al. 2002).
3. Many CAMS work beyond the single causal relationship model, and as such need to be investigated using models that unearth the multiplicity of effects. This may or may not suit many quantitative researchers. Especially in the context of Sackett's hierarchy of evidence, where randomized control trials

are presented as a higher level of evidence than cohort control studies or qualitative research, CAM research tends to be marginalized and underfunded (Gaydos 2001; Peters, Chaitow et al. 2002).

4. Given the small numbers of refugees in Western countries, they fall below the radar in terms of research and the building of an evidence base to use for clinical decision-making (Murray and Skull 2003; Correa-Velez, Sundararajan et al. 2007).

What these issues reinforce is the need for any integrative system of medicine to be supported by a strong research investment, one that is flexible and open to alternative forms of investigation to provide the evidence base.

The reality is that CAMs have become part of the reality of daily life along with biomedicine and the different modalities have to work together towards achieving the best possible outcomes in terms of health. As Libster (2001:104) says:

While patients are going to their CT practitioner they are continuing to visit their biomedical practitioner. Our patients are already using an integrative model for their health care.

This point is further reinforced by Lien (1994:56) in recounting the fact that Vietnamese refugee patients, during their psychiatric treatment, continued to return to their traditional remedies in search of quicker cures. Shelley Adler describes this process as:

[p]atients' integration of biomedical and CAM therapies is, of course, not desperate and haphazard, as historically depicted in the biomedical literature; patients' health care practices are deliberate and complex. My research with women with breast cancer indicates that individuals combine disparate elements—from what may appear to be mutually exclusive health traditions—into a syncretic whole. (2002:412-413)

Andrews and Boon (2005) suggest that structural integration is taking place at several levels. At one level, patients are integrating CAM modalities and biomedicine towards managing their own health. At another level, medical practitioners are incorporating CAMs into their own practices either providing the service through a CAM practitioner or retraining themselves to become dual

practitioners. And finally, there is the emergence of the integrative clinic, where conventional and CAM practitioners work together in partnership, as a real representation of integration in clinical practice.

Summary

This chapter explored the literature on different health systems including the biomedical model and complementary and alternative medicine systems. The biomedical model is currently the dominant paradigm in Western medicine. Over the years, the biomedical model has come under criticism for a number of reasons, particularly in adopting rigid positivist approaches and not taking into consideration the psychological, social and environmental factors in determining health outcomes. The chapter reviewed the ways in which factors in biomedicine interact with refugee health and its limitations in addressing key health issues. The analysis of the issues with these systems suggests that multi-disciplinary and multi-pronged approaches that work in an integrative medicine paradigm to address all the major factors impacting on the health of refugees at various levels of the system are likely to be more effective than the present dependence on the biomedical paradigm. They would ensure that the key aspect of integration evolving from the biomedical to the biopsychosocial and the spiritual is accompanied by a basic trust in the capacity of self-healing in each person, a relationship of partnership between practitioners of different traditions as well as with the clients, an availability of a range of interventions, self-empowerment of the client through education, support and involvement in decision-making, as well as use of evidence where available accompanied by a significant investment in research. In the next chapter I focus on a subset of CAMs, i.e. yoga, yoga therapies and the health of refugees.

Chapter 4: Yoga and the Health of Refugees

Yoga is an ancient Indian tradition, traced back to over 5000 years as attested to by depictions of yoga postures on archaeological artifacts of the period (Tullis 2007). This tradition has spread extensively to the West over the last hundred years and yoga has come to be practiced as an exercise form, a healing therapy as well as a

spiritual path (Birdee, Legedza et al. 2008). In this chapter I examine the themes that emerged from the literature of yoga in the context of its application in supporting the health of refugees. I first present the background of yoga including a short history of modern yoga as it spread to the West from India, the extent of its popularity as well as acceptance by the mainstream in the present day. The theories and principles of yoga are then explained and their applications to health as yoga therapy are described. One of the common complaints in the past relating to CAM therapies has been the lack of scientific evidence as to their efficacy (AMA 2002; WHCCAMP 2002). A number of research studies have been undertaken over the last few decades to provide a stronger scientific basis for their incorporation as health interventions and I close the chapter with a review of the scientific research and evidence around the therapeutic applications of yoga with a specific focus on the health of refugees.

Background of Yoga

The word ‘Yoga’ is derived from the Sanskrit term ‘Yuj’ meaning ‘to yoke’ or ‘to join’ or to ‘join together’ (Penman, Cohen et al. 2008) which at the philosophical level refers to the joining of the individual consciousness and the universal consciousness or to the yoked reality of the human’s experience of body, mind and spirit (Taylor 2004). At the practical level, the term is widely used to refer to that group of practices originally from India that develops harmony in the body, mind and spirit (Feuerstein 1998). In the Indian traditions, these groups of practices or pathways include *Gyana Yoga* or the yoga of knowledge and the intellect, *Bhakti Yoga* or the yoga of devotion, *Karma Yoga* or the yoga of selfless service and *Ashtanga Yoga* or the eight-limbed path incorporating rules of living with physical, mental and spiritual practices. While many of the pathways are closely linked to Hinduism, *Ashtanga Yoga* lends itself to secular practice and is widely practiced across the world by people of many religions as well as by those with no religious affiliations as it makes no dogmatic demands of belief (Taylor 2004).

Ashtanga Yoga is sometimes viewed as two yoga systems called *Hatha Yoga*, focusing on practices of the body and the breath, and *Raja Yoga* that focuses on meditation and cultivation of the mind, while other scholars use *Raja Yoga* as another name for *Ashtanga Yoga* (King and Brownstone 1999; Penman, Cohen et al. 2008; SYA 2010). In the West, the term ‘Yoga’ is used almost always to refer to *Ashtanga Yoga* and/or *Hatha Yoga* and *Raja Yoga*, and for the purposes of this thesis

the term will be used to identify the combination of physical postures, breath control techniques, and relaxation and meditation techniques that make up the practices of *Ashtanga Yoga*, *Hatha Yoga* and *Raja Yoga*.

In terms of classical yoga literature, the principles of *Ashtanga Yoga* were first compiled into the 198 aphorisms (terse statements of truth) of the ‘Yoga Sutras’ by the Sage Patanjali (somewhere between 200 BCE and 200 CE) (Miller 1996; Slede and Pomerantz 2001). *Hatha Yoga* has its roots in the ‘Hatha Yoga Pradipika’, a text ascribed to Swami Svatmarama (15th century CE). There is also a lengthy exposition of the different forms of yoga in the ‘Bhagavad Gita’, one of the most sacred Hindu texts which has a number of dates ascribed to it, ranging from the 5th century BCE to the 1st century CE (Miller 1996). Other important classical texts include the 18 *Upanishads*, the *Gheranda Samhita*, the *Shiva Samhita*, and the *Yoga Vasistha* (Penman, Cohen et al. 2008).

Yoga traditions began to be popularized in the West from the end of the 18th century, largely through the efforts of charismatic teachers like Swami Vivekananda, Swami Yogananda, T. Krishnamacharya and B.K.S Iyengar to name a few (Nikhilananda 1996; Serber 1998; Desikachar 2010). The many different lineages and traditions of yoga have developed into a multiplicity of names which can be quite confusing. The Yoga Teachers Association of Australia refers to at least 19 different names of styles of yoga (YTAA 2010). The following table elaborates on some of the popular styles of yoga in the West highlighting some of their focus areas.

Table 4.1: Styles/Schools of Yoga

Yoga School/Style	Focus area and description
Anusara	Focuses on celebration of the heart, balance in energetic action and universal principles of learning using a student-centred approach.
Ashtanga Vinyasa	Based on approaches popularized by K. Pattabhi Jois, this is a very athletic and popular style that focuses on yoga postures linked together in dynamic sequences. Not easily used as yoga therapy.
Bikram/Hot	Popular style based on a sequence of postures practiced in a pre-heated room. Not easily used for therapy.
Classical	Any practice based on the philosophy and practices delineated in Patanjali’s Yoga Sutras.
Dru	A calm and graceful form of yoga based on soft, flowing movements and focusing on directed breathing and visualizations.
Hatha	A major branch of yoga focusing on postures, breath and cleansing techniques.
Integral	Integration of yoga teachings and everyday life and relationships. Uses all the areas of Ashtanga

	Yoga. Based on the teachings of Swami Satchitananda.
Iyengar	One of the most popular and organized schools of yoga, this is based on the approaches of B. K. S. Iyengar. It focuses on precision in practice, therapeutic uses of yoga as well as the use of props to make yoga more accessible to practitioners.
KHYF	Focused on the teachings of T. Krishnamacharya, this lineage is associated with his son, T. Desikachar and has a strong emphasis on yoga as therapy. Poses are synchronized with the breath in sequences. The term 'Viniyoga' is sometimes used to describe this school but is more often reflective of the style taught by Gary Kraftsow, also based on the KHYF tradition.
Kripalu	Gentle practices focused around meditation during asana practice, alignment and use of breath.
Kundalini	Uses traditional yoga practices with a focus towards raising the dormant energy at the base of the spine through the various chakras (energy plexuses). Often used in the West to refer to yoga as taught by Yogi Bhajan.
Satyananda	Hatha yoga practices with some Tantra practices. This school is particularly well known for meditative/relaxation practices like Yoga Nidra.
Sivananda	Traditional Ashtanga/ Hatha Yoga as taught by Swami Sivananda.
Sudarshan Kriya Yoga (SKY)	This is a group of yoga breathing techniques that are taught by through the 'Art of Living' Foundation. SKY has been utilized to work with the trauma of Hurricane Katrina survivors and 9/11 survivors.
Tantra	Focuses on the use of sexual energy for wholeness to everyday life as well as towards spiritual enlightenment. Includes life modification practices, visualization, and asana and breath practices.
Vivekananda	Yoga tradition based on the teachings of Swami Vivekananda. Practices involve all aspects of yoga as delineated by Sage Patanjali.

(Sivananda 1994; Serber 1998; Jois 2002; Taylor 2004; Gerbarg and Brown 2005; Parnell 2005; SVYASA 2006; Dru 2008; Galantino, Galbavy et al. 2008; Penman, Cohen et al. 2008; HMS 2009; ISYVC 2009; KHYF 2010)

While the names and 'brands' ascribed to yoga are many, the majority of them describe the practice of *Ashtanga Yoga* or *Hatha Yoga/ Raja Yoga* (Penman, Cohen et al. 2008; YTAA 2010). Marie Janisse (2002:2) suggests that:

[w]hile they differ in outward form, a common thread is the intent to enhance self-awareness. On the level of thought/emotion (known as 'mind' in eastern philosophy), self-awareness centres on issues of personal mastery and relationship to others. On the physical level, the westerner appreciates increased strength, flexibility, stamina and balance. From the perspective of Yoga, these physical benefits are merely by-products of a bio-energetic system powered by prana, the life force ('chi' in Chinese medicine). Yoga values the increase in overall vitality and organ strength, and more importantly, the ability to direct the mind and the body.

Participation in Yoga

Yoga in the West has undergone major changes over the last few decades. From an exoticized and sometimes vilified form of body/mind/spirit practice it has become mainstream, as can be seen in terms of the participation rates, the use in clinical settings as well as the professionalization of the industry (Douglass 2007; Penman, Cohen et al. 2008) as will be delineated in this section.

In terms of participation rates of people in yoga, Birdee et al. (2008) used data from a 2002 National Health Interview Survey to determine that 5.1 per cent of U. S. adults practiced yoga. By 2008, another study commissioned by the Yoga Journal found that 6.9 per cent of U. S. adults, approximating 15.8 million people, practice yoga. Of these 72.2 per cent were women and 27.8 per cent men (YJ 2008). In Australia, the Australian Bureau of Statistics, based on 2006 census figures, delineates a yoga participation rate of 1.7 per cent of all adult Australians, around 268,700 people, 90 per cent women and 10 per cent men, just ahead of participation rates for Aussie Rules Football (ABS 2010) Yoga participation data is also available from the Australian Sports Commission which publishes annual data of sports participation culled from its Exercise, Recreation and Sport Survey (ERASS). In 2009, they reported yoga participation rates of 2.8 per cent, comprising 488,400 respondents (ERASS 2009:62) with a male participation rate of .5 per cent and female participation rate of 5.1 per cent (2009:63). Another study by Xue et al. (2007) looking at the therapeutic use of CAMs in Australia reported much higher rates of 12 per cent for the uptake of yoga for health. A New Zealand survey also shows relatively high participation rates of 9 per cent with 85.3 per cent women and 14.7 per cent men (SPARC 2009).

The anecdotal evidence from India is that men and women practice yoga at least in equal proportions while the statistics in the West generally show a very high proportion of women as against men (YJ 2008; SPARC 2009; ABS 2010). Some explanation of this is offered by the Yoga Journal (YJ) (2003) when it polled readers on why men were more reluctant to do yoga than women. Of the total number of 1,477 participants, the highest proportion (34 per cent) said that men feared embarrassment in class, while 31 per cent said that men didn't think they would get a good enough workout, 25 per cent said men were not interested in the quiet non-competitive aspects of yoga while 10 per cent said that men were unaware that yoga

is an option for health and healing (YJ 2003). However, the proportion of men who do not participate in yoga and who responded to the survey is not known, raising the issues of the actual reasons for non-participation as against the perception of what those reasons are.

Yoga in the West continues to have a focus on the physical body, as emphasized in the 'Yoga in Australia' survey conducted by RMIT University (Penman, Cohen et al. 2008) where 70 per cent of the participants stated that their reasons for starting yoga were health/fitness and flexibility/muscle tone, a figure increasing to 80 per cent as the same reasons for continuing. However, 57 per cent also gave the reduction of stress as another reason for starting, a figure that escalated to 76 per cent as the reason for continuing, a figure close to the figures for the physical aspect. Further 20 per cent also stated that they had a health or medical reason for practicing yoga. Where yoga had been used to treat any kind of health condition, 96 per cent of those who practice reported that their condition was improved by the practice of yoga (Penman 2006:2).

Birdee et al. (2008), in a national survey of yoga users in the United States, reported that yoga was most commonly used to treat musculoskeletal or mental health conditions, and most users reported yoga to be helpful for these conditions. A majority of yoga users (61 per cent) believed that yoga was important in maintaining health. The 2008 Yoga Journal survey indicates that almost half (49.4 per cent) of people practicing yoga did so to improve their overall health and that 6.1 per cent of all the people surveyed said that a doctor or therapist had recommended yoga to them as a therapy (YJ 2008). This increasing acceptance of yoga by medical professionals is also reported by Schrader (2008) in a study of Australian health professionals, including general practitioners, chiropractors, naturopaths, physiotherapists and osteopaths, wherein 83 per cent had recommended yoga to their patients for a range of conditions including anxiety disorders, musculoskeletal degenerative disorders, other general muscular disorders, mood disorders and sleep disorders.

In the context of mainstream acceptability, the Pain Management Task Force report, commissioned by the U. S. Army Surgeon-General in 2010, identifies yoga at the highest level of acceptability as a CAM that could be utilized for the management of pain, based on efficacy, safety, and widespread use as well as appropriate licensing

and credentialing arrangements (PMTF 2010). Yoga is increasingly found in clinical settings either as a stand-alone or as part of an integrative medicine service. In India, the 'Advanced Centre for Yoga- Mental Health and Neurosciences' in Bangalore has been promoted by the National Institute of Mental Health and Neurosciences (NIMHANS), an internationally recognized mental health institution. The centre offers yoga therapy services to people suffering from psychiatric and neurological disorders such as schizophrenia, depression, anxiety disorder, obsessive compulsive disorder, attention deficit hyperactivity disorder, epilepsy, migraine, back pain, cervical and lumbar spondylosis, and mild cognitive impairment as well as for caregivers of psychiatric/ neurological patients (ACY 2009). Yoga also forms part of the integrative medicine options for cancer survivors and caregivers at one-fourth of the comprehensive cancer care centres in the United States (SMCC 2010), including at the MD Andersen Cancer Centre at the University of Texas (Le and Winters 2010), the Stanford Medical Cancer Centre (2010) and the Memorial Sloan-Kettering Cancer Centre (MSKCC 2011).

Yoga is also found as part of the integrative medicine practices and hospitals at a number of locations including: Duke Integrative Medicine in North Carolina, USA; Centre for Integrative Medicine, University of Maryland School of Medicine, USA; Osher Centre for Integrative Medicine at the University of California Medical Centre, USA; Beth Israel Medical Centre in New York City, USA; Greenwich Hospital, UK; Graduate School of Integrative Medicine, Swinburne University, Melbourne, Australia; Sri Ganga Ram Hospital, New Delhi, India; and the Sri Ram Manohar Lohia Hospital, New Delhi, India. Yoga also forms part of the range of services provided by several torture and trauma services in Australia (GH 2000; Maley 2004; FASSTT 2006; DIM 2009; Myers 2009; SGRH 2009; CIM 2011; UCSF 2011).

Yoga has become part of university or continuing education in a number of international settings. Continuing education workshops on yoga are run at the University of Maryland, School of Social Work in the United States. Similar workshops are run at the Simmons College of Social Work in Boston to help social work clinicians develop an understanding of the benefits of yoga integrated into their practice (Sisk 2007). The Advanced Centre for Yoga at NIMHANS, Bangalore,

India, also runs yoga appreciation courses to enable medical professionals to understand and utilize yoga in their practice (ACY 2009).

While a significant amount of work in yoga as therapy continues to be done in India under the umbrella of the Indian government's Department of AYUSH (NIC 2010), the international levels of acceptability of yoga as therapy have much to do with the work of the International Association of Yoga Therapists (IAYT) (Penman, Cohen et al. 2008). This organization provides a platform for therapists to come together at conferences as well as publishing research papers in their journal, the 'International Journal of Yoga Therapy' (IAYT 2010). In Australia, yoga therapy has been recognized in the formation of the Australian Association of Yoga Therapists as well as the first nationally recognized training course, the 'Graduate Certificate in Yoga Therapy' (Penman, Cohen et al. 2008). In the context of the focus of this thesis on the health of refugees, while there are numerous certificate programs in yoga teaching and yoga therapy run across many countries across the world, very few of them focus on the specific issues that impact on refugees. One program that is worthy of mention here is one run by the Trauma Centre in Brookline, Massachusetts, USA, a 40-hour advanced certification for yoga teachers towards the teaching of yoga to the survivors of trauma. While not specifically focused on refugee trauma it is one of the few yoga programs that are specifically designed for and offered to women and men who are survivors of physical, emotional and sexual abuse and neglect. The classes are offered in a variety of settings including schools, veterans' centres and domestic violence centres (Emerson, Sharma et al. 2009:124). Some of the main principles of trauma sensitive yoga practice as utilized by this centre are explored further in chapter 7 on yoga themes.

Theory and Principles of Yoga

Yoga is delineated as 'yogah chittavritti nirodaha' in *Sutra* 1.2 of the 'Yoga Sutras' (Iyengar 1993:45; Venkatesananda 2008:7), or the inhibition of the fluctuations of thought/mind/ego-complex (Miller 1996; Slede and Pomerantz 2001; Taylor 2004). Yoga gives us 'ways of understanding the functions of the mind, and helps us to quieten their movements, leading one towards the undisturbed state of silence which dwells in the very seat of consciousness (Iyengar 1993:46). The goal is that of a consciousness that is unprejudiced and is able to make an unattached analysis of the world around, and of individual situations (Fishman 2005). The physical body is just

one of the tools that are used in yoga to harness the mind and enable it to be focused and stable leading to many benefits including the physical benefits of enhanced flexibility, posture, balance, strength and physical health (Taylor 2004).

The nine obstacles to the goal of clear consciousness, obstacles that can be described as the pathological states of the human being are delineated in *Sutra* 1.30 as: *vyâdi* (somatic disturbance or illness), *styâna* (gloominess or dullness), *samshaya* (doubt), *pramâda* (procrastination or carelessness), *âlasya* (sloth), *avirati* (attachment or obsession on the obstacles), *bhrânti-darshana* (hallucination or distorted vision), *alabdha-bhûmikatva* (failure to attend with concentration or inability to establish firm ground) and *anavasthâ* (instability or unsteadiness of mind) (Iyengar 1993; Slede and Pomerantz 2001; Venkatesananda 2008).

These nine states are accompanied by four reactions, described in *Sutra* 1.31 as: *duhkha* (pain), *daurmanasya* (anguish and despair), *angamejayatva* (trembling in the body) and *shvâsa prashvâsa* (issues in respiration) (Iyengar 1993; Slede and Pomerantz 2001:61; Venkatesananda 2008). While Slede and Pomerantz (2001) suggest that this outline of psyche-related symptoms and diagnoses are similar to those found in the Diagnostic and Statistical Manual widely used by Western psychologists and psychiatrists today, the yogic paradigm of health and illness is very different from that practiced in the West, and looking for these kinds of parallels and it is likely to be misleading to seek for this kind of common ground (Stiles 2008).

The ‘Yoga Sutras’ describe the eight practices of *Ashtanga Yoga* that are used to overcome the nine obstacles and the four reaction states. These include:

1. *Yama*: These are moral guidelines and may be viewed as tenets of social discipline or inter-people restraints that form part of a yogic lifestyle. They include *ahimsa* or non-violence, *satya* or truthfulness, or *asteya* or abstaining from stealing, *brahmacharya* or chastity, and *aparigraha* or non-coveting. These help to guide the yogi towards the cessation of conflict in his/her relationships with the outer world.
2. *Niyama*: These are qualities that nourish, or tenets of individual self-discipline. They include *saucha* or purity/cleanliness in body and mind, *santoshâ* or contentment, *tapas* or persevering/intense effort, *svadhyaya* or

study of the Self, and *isvara-pranidhan* or devotion to a higher calling or power. These tenets help the yogi towards the cessation of conflict within themselves.

3. *Asana*: These are physical postures and/or define a firm, steady stance. They involve moving the body into a position, staying in that position and then moving out of the position. They are practiced with the qualities of stability, ease and minimal effort and work towards developing these qualities in both the body and the mind of the practitioner. They also work towards creating the attitude of mindfulness or being in the moment through the practice of focus.
4. *Pranayama*: Breath exercises or control of energy through the breath. The breath is consciously regulated or observed, with a focused mind and a still body. The breath in turn causes a complex set of changes within the body and the mind depending on the nature of the pranayama used. As such, the mind and body can be stilled or energized through breathing techniques.
5. *Pratyahara*: Withdrawal inward from the senses, or decreased reactivity to the senses. Bringing the awareness within oneself and withdrawing from the world as perceived through the senses. This is the first step towards meditation. There are specific postures and breath techniques that can be used for this.
6. *Dharana*: Focused concentration or placing the awareness at one point through any one sense, such as sight or hearing, or focusing on any one point within the mind. Concentration prepares one for the practice of meditation.
7. *Dhayana*: Stilling of the mind, meditation, mindfulness. The process of focusing the mind on an object or symbol takes the practitioner to the point where the mind is still and calm and the practitioner goes beyond the causal relationship of observer and observed.
8. *Samadhi*: Fusion of the individual and the universal, or self-realization

(Iyengar 1993; Slede and Pomerantz 2001; Taylor 2004; Mohan 2006).

The concept of the eight different levels of practice is of great relevance when applied towards dealing with disease and suffering, as they work with different aspects of the human being and create a holistic effect (Mohan 2006). The process of

utilizing this paradigm towards the therapeutic application is what is commonly referred to as yoga therapy (Kepner, Strohmeier et al. 2002).

Yoga Therapy

Yoga therapy, as it exists today, is a modern phenomenon resulting from the encounter between Western medicine and science and the development of modern yoga in India (Singleton cited in McGonigal 2010:18). In the context of a health care setting, John Kepner (2002:26) suggests that yoga therapy is:

instruction in specific Yoga practices and teachings to prevent or alleviate structural, physiological, psychological and/or spiritual pain, suffering or limitations. In a therapeutic context, this is usually taught one on one by appropriately trained yoga teachers for the specific conditions and goals of the individual student.

It is distinct from the older Indian tradition of yogic healing which is known, in classical Sanskrit, as *yoga-cikitsâ* or yoga utilized to oppose disease or ill-health (Mohan 2006). The literature demonstrates a clear need to differentiate between yoga and yoga therapy (Mohan 2006; Feuerstein 2007) as:

[y]oga therapy is of modern coinage and represents a first effort to integrate traditional yogic concepts and techniques with Western medical and psychological knowledge. Whereas traditional Yoga is primarily concerned with personal transcendence on the part of a "normal" or healthy individual, Yoga therapy aims at the holistic treatment of various kinds of psychological or somatic dysfunctions ranging from back problems to emotional distress. Both approaches, however, share an understanding of the human being as an integrated body-mind system, which can function optimally only when there is a state of dynamic balance.

(Feuerstein cited in Slede and Pomerantz 2001:62).

Scholars also argue that yoga was never designed to be stand-alone therapy, rather it is a way for individuals to empower themselves to progress towards greater health and freedom from disease (Mohan 2006). Yoga therapy works very effectively as a complement to other therapies, and participants can continue with any form of

medication or treatment that they are using (McCall 2007; Sisk 2007) such as acupuncture, massage, homeopathy and biofeedback, as well as biomedicine and psychotherapy (Carter and Byrne 2003; Mohan 2006; Stiles 2008; PMTF 2010). Yoga can amplify the effects of these other therapies leading to dosage or therapy reduction. Further, unlike many other CAMs that can have harmful interactions, yoga practice is very unlikely to interact in a negative way with any other treatment (McCall 2007).

Bossart (2007) further suggests that the therapeutic basis of yoga is not reliant on the use of yoga techniques but on the yogic understanding of the human system, one that is very different from that of Western medicine. These two systems, while able to complement each other in terms of achieving the best possible outcome for the patient, differ in many other ways in terms of their approach. Douglass and Tiwari (2006) reflect on these ways that Yoga *Cikitsâ*, or yoga therapy, differs from Western biomedicine or as they refer to it, Allopathic medicine. Firstly, they argue that biomedicine emphasizes the role of the doctor in the healing process while yoga therapy focuses more on the actions of the patient, thereby empowering the patient. Secondly, they suggest that yoga therapy seeks to heal rather than cure, which could even mean the acceptance of one's condition. They argue that this is a better approach for chronic, long-term illnesses than the traditional 'cure' approach of biomedicine. Finally they point out that yoga therapy's emphasis on spirituality and on relationships as part of the healing medium also makes it a powerful complement to biomedicine (Douglass and Tiwari 2006:24).

Additionally to this, McCall (2007) argues that biomedicine is best at dealing with acute problems and not so effective with chronic ones while yoga therapy is not so effective in acute problems and more so in chronic ones. He also suggests that yoga therapy works better than biomedicine in issues that are named 'psychosomatic' in the medical world.

The yogic view of health is stated in the Yoga Sutra 2.2 as *samadhi bhavanarthah*, describing a state beyond the absence of affliction (Iyengar 1993:100), a definition very reminiscent of the World Health Organization's definition of health as 'a state of complete physical, mental and social well-being and not just the absence of

disease or infirmity' (WHO 1948). While yoga therapy may be focused towards the removal of particular afflictions, it still remains a paradigm that, unlike traditional biomedicine, nurtures the health of the individual, and works towards health enhancement through stress management, dealing with spirituality and meaning issues, dietary and nutritional counseling, exercise and fitness as well as addiction or habit management (Jonas and Levin 1999; Cohen 2003). It optimizes the function of every system in the body and mind, addresses the imbalances that lead to disease (Swami Satchidananda cited in Serber 1998; McCall 2007) and is:

a preventative healing art, science and philosophy by which we build up robust health in mind and body and construct a defensive strength with which to deflect or counteract afflictions that are as yet unperceived afflictions.

(Iyengar 1993:117).

Yoga works on many of these levels simultaneously, using *asanas* and *pranayama* for the physical body and through it, the subtle body, and using the different levels of meditation as well as the yogic lifestyle to work with the subtle body directly (Johnson and Kushner 2001; Mohan 2006; Stevens 2006). Further, as Penman et al. (2008:6) argue, yoga has a positive effect on health as well as longevity due to the choices associated with a yogic lifestyle including healthy eating, vegetarianism, reduced smoking, reduced alcohol consumption, increased spirituality, and reduced stress. Yoga changes the way that practitioners experience the world around them and provides the tools with which the practitioner can analyze his/her own thought processes and come to a clear understanding of their human identity (Miller 1996).

The four core principles of yoga therapy have been summarized by Desikachar et al. (2005:17) as: *Holism*, where the human system is comprised of different dimensions that are interrelated and inseparable from each other; *Uniqueness*, where each person's problems must be approached in a manner that addresses the unique needs of that individual; *Self-empowerment*, where every person assumes responsibility for their own healing and; *Power of the Mind*, where a positive mind set supports the healing process. Further to these four principles, Douglass and Tiwari (2006) suggest that the principle of collaboration with other health modalities has always been part of the nature of yoga therapy.

The principles outlined here guide the ways in which the various techniques of yoga are utilized towards healing many different levels. *Asanas* are very effective in working with problems of a musculoskeletal nature because of the nature and precision of the postures as well as the relationship between the breath and the movement (Mohan 2006). Further, they also help towards regulation of natural diaphragmatic breathing, calming of stress responses and towards developing a state of calm alertness (Johnson and Kushner 2001). *Asanas* work towards improving positive moods, reduction of negative moods and increases in energy levels (Shapiro and Cline 2004; Sisk 2007), as well as helping to develop an attitude of mindfulness and of being in the moment, which is one of the essential factors towards improved physical and mental health (Kabat-Zinn 2003). They also help prepare the participant for the practices of *pranayama* (Vahia, Vinekar et al. 1966). However, in the acute stages of an illness or trauma, *asanas* may not be very useful, whereas many of the other tools of yoga therapy, such as breathing techniques, may prove more useful (Elgelid 2008).

Pranayama or the group of breath techniques also work at a number of levels as therapy. The rate and depth of breath affects both the physiological functions and the psychological functions, with correlations drawn between the breath, constriction in the muscles and the levels of well-being or stress and anxiety (Vahia, Vinekar et al. 1966; Stevens 2006). Breathing practices can be used to create a more relaxed state or to generate a more dynamic energetic state, depending on the perceived need of the practitioner (Johnson and Kushner 2001; Sisk 2007). By controlling the breath, the emotions and other mental states can be controlled (Stevens 2006). From a scientific framework, yogic breath techniques are an example of peripheral feedback leading to an emotional response by affecting the autonomous nervous system and inducing changes in emotion, thinking and consciousness (Gerbarg and Brown 2005).

Another powerful tool used in yoga is *savasana* or relaxation in the corpse position. Through a process of retraining the body and the mind to relax through focused muscular relaxation and deep breathing, the practitioner develops a habit of relaxation that works very well towards turning off the stress response (Serber 2000). Similarly *yoga nidra*, a guided mediation in the prone position, also helps to develop the relaxation response and transcend it using visual imagery and affirmations. This

combination of relaxation and imagery can influence a wide range of physiological functions such as heart rate, blood pressure, brain wave rhythms, peripheral blood flow, gastrointestinal activity, as well as the release of various hormones and neurotransmitters, while also reducing anxiety and stress levels (Johnson and Kushner 2001).

Dharana, *Dhyana* and *Samadhi*, are different levels of concentration and meditation in *Ashtanga Yoga*. These also have very significant impacts on the physiological functions of the body by decreasing heart rate, respiratory rate, oxygen consumption and moderating blood pressure (Johnson and Kushner 2001). Meditation can improve people's sense of well-being and feelings of calm and rest (Johnson and Kushner 2001) as well as lowering levels of anxiety and stress (Gupta, Khera et al. 2006). Miller et al. (1998) report in their follow up of the use of mindfulness meditation with people diagnosed with anxiety disorders, that substantial and long-term benefits of the program were recorded even after three years.

From a Western scientific framework, some explanations that are given of the ways that yoga can be seen to alleviate many physiological and psychological issues include that yoga works by relaxing chronic muscle tension and optimizing respiratory function (Goyeche 1977 cited in Slede and Pomerantz 2001:64) and by generating a state of calm alertness involving an 'increased parasympathetic drive, calming of stress response systems, neuroendocrine release of hormones, and thalamic generators' (Brown and Gerbarg 2005:189). Many of the practices can lead to positive stimulation of the pressure receptors leading to enhanced vagal activity and reduced cortisol, which can in turn lead to positive effects like enhanced immune function and lower prematurity rate (Field 2011). The effects of deep breathing and other breath practices on calming the nervous system are effects that are substantiated in effects reported in the scientific studies of psychoneuroimmunology (Johnson and Kushner 2001; Gupta, Khera et al. 2006). All of these practices impact on the brain, the autonomic and the central nervous system, providing a cause-effect explanation that fits with the biomedical/Western scientific framework as explanations of the efficacy of the practice of yoga (Slede and Pomerantz 2001).

One of the most comprehensive books on yoga therapy is 'Yoga as Medicine' by Timothy McCall, who is a medical practitioner himself (McCall 2007). He

summarizes the health benefits of yoga practice, largely in a physical sense, as below.

Table 4.2: 40 Ways Yoga Heals

1- Increases Flexibility	21- Improves the Function of the Nervous System
2- Strengthens Muscles	22- Improves Brain Function
3- Improves Balance	23- Activates the Left Prefrontal Cortex
4- Improves Immune Function	24- Changes Neurotransmitter Levels
5- Improves Posture	25- Lowers levels of the Stress Hormone Cortisol
6- Improves Lung Function	26- Lowers Blood Sugar
7- Leads to Slower and Deeper Breathing	27- Lowers Blood Pressure
8- Discourages Mouth Breathing	28- Improves Levels of Cholesterol and Triglycerides
9- Increases Oxygenation of Tissues	29- Thins the Blood
10- Improves Joint Health	30- Improves Bowel Function
11- Nourishes Intervertebral Disks	32- Uses Imagery to Effect Changes in the Body
12- Improves Return of Venous Blood	33- Relieves Pain
13- Increases Circulation of Lymph	34- Lowers Need for Medication
14- Improves Function of the Feet	35- Fosters Healing Relationships
15- Improves Proprioception	36- Improves Psychological Health
16- Increases Control of Bodily Functions	37- Leads to Healthier Habits
17- Strengthens Bones	38- Fosters Spiritual Growth
18- Conditions the Cardiovascular System	39- Elicits the Placebo Effect
20- Relaxes the Nervous System	40- Encourages Involvement in Your Own Healing

(McCall 2007:30)

Yoga therapy is not a practice that can be utilized by every person for every need. Slede and Pomerantz (2001) submit that acutely psychotic patients may not benefit from yoga practices and may even be harmed by the practice, raising the issue that a thorough evaluation of mental status needs to be conducted prior to yoga therapy treatment in the case of patients with suspected mental health issues. As the healing process of yoga is dependent on the ability of the student of patient to follow instructions, people with acute mental illnesses or drug addictions would find it very difficult to utilize yoga therapy techniques (Desikachar, Bragdon et al. 2005). However, yoga is of benefit in drug rehabilitation programs where its practice enables people to balance and stabilize their bodies and minds during the rehabilitation process (Slede and Pomerantz 2001). Many of the techniques of yoga therapy may also not be accessible to people in the acute stages of disease or in emergencies, where other healing modalities like surgery, chemotherapy or

acupuncture may be more advisable (Elgelid 2008). But even in these circumstances, yoga can provide support through the process and also help in dealing with side-effects (Kabat-Zinn 2003).

While evidence will be presented later in this chapter on the efficacy of yoga as a healing modality for trauma survivors, such as many refugees, caution has to be exercised in terms of the environment, the class content, the physical assistance (assists) provided by the teacher or therapist, the teacher's attitude, the language used as well as the choices available to the participants in a yoga class. Emerson et al. (2009) in their paper on 'Trauma-Sensitive Yoga', excavate these factors in some detail. They suggest that a key principle to be followed is that of '*ahimsa*' (non-violence or in this case non-harming) both as an ethical construct for yoga teachers as well as a guide to students to be kind and compassionate towards their own bodies. Secondly they argue that reclaiming the body is very important to traumatized people for whom the body is often the seat of great pain, abuse and neglect.

Trauma-sensitive yoga should be practiced towards helping people reclaim their bodies and clear up ownership issues to some extent. From establishing ownership people can then move on towards befriending the body. The language used by the yoga teacher is very important to the practice and the authors suggest using the *Language of Inquiry* (words like notice, curious and investigate) as well as *Invitatory Language* (phrases like 'when you like' 'at your own pace' and 'if you like') to remind students that they have a body and have control over what they do with that body. Further, this would also help people to be less demanding on their bodies and minds and focus more on the spirit of inquiry. They also recommend the development of practices to help students self-regulate or use the body as a resource. Traumatized people are often triggered and have their nervous system hijacked by these triggers. Yoga practices, such as *pranayama*, can help many people in these circumstances to self-regulate and to calm down (2009:5-10).

Emerson et al. (2009) go on to suggest that yoga teachers working with traumatized people should approach physical assists, where the teacher physically helps the student to attain a position, with great caution, and to avoid them altogether in short-term classes. They should be replaced with verbal assists and guidance instead. In

terms of the qualities of a trauma-sensitive yoga teacher, they include a light hearted appearance (plenty of smiles), being engaged, welcoming and approachable as well as being competent and allowing the student to have their own experience rather than being directive. In terms of the environment, the place of practice should not have open, exposed windows, disturbances in the form of equipment noise or people wandering through, mirrors, or music that can be distracting and promote dissociation. They also recommend that the pace of instruction be appropriately slow and avoiding of too much challenge in the form of difficulty of the postures and the intensity of practice (2009:11-14).

Yoga teachers also need to develop specific sets of skills to work in specific areas of health such as those associated with trauma. As an example, a refugee who has survived torture before settling in Australia may react adversely, or be triggered into a flashback, by the use of ropes and belts that are commonly used as props in Iyengar yoga classes, or by visualizations that are not carefully chosen. Another example relates to the levels of expertise needed when considering work within a hospital environment. The set of skills required here may include a ‘thorough knowledge of human physiology and anatomy, especially as it relates to the conditions that you will encounter in the unit where you wish to serve’ as well as an ‘understanding of the course of the illnesses or injuries that you are most likely to encounter’ (Lilly 2009:114). This complex set of skills becomes necessary for a host of administrative, legal and safety issues as well as for integrating the practice of yoga into the hospital’s model of patient care and working with patients and their families (Lilly 2009).

Scientific Evidence of Yoga as Therapy:

While the practice of yoga does not lend itself easily to the Western scientific framework that determines modern research methods, the last few decades has seen an increasing number of research studies that have examined different aspects of yoga especially in the context of yoga as therapy. Further, the last decade has seen a small but significant number of systematic reviews that summarize the data available of yoga research studies. Penman et al. (2008) used the PubMed (Medline) database to examine a number of the research studies up to 2006 in the areas of yoga, meditation and health, in the context of scientific rigor, using the National Asthma Council Australia Effectiveness scale (Appendix 8).

This meta review examined and classified, in terms of scientific rigor, research on yoga practices in the areas of cardiovascular health, mental health, musculoskeletal health, women's health, respiratory health, gastrointestinal health, cognitive/function/neurological conditions, cancer care, and seniors and carers. The results summarized the meta-analyses and RCTs published between 1985 and 2007 and are as follows:

Table 4.3: Yoga in Australia Survey: Summary of Evidence

	3+	2+	1+	+/-	1-	2-	3-	0
Cardiovascular health	-	2	34	2	1	-	-	-
Mental health	-	3	29	7	2	-	-	-
Musculoskeletal Health	-	4	10	1	-	-	-	-
Women's health	-	1	6	3	1	-	-	-
Respiratory health	-	-	5	6	2	-	-	-
Gastrointestinal health	-	-	3	2	-	-	-	-
Cognitive function/ neurological conditions	1	4	12	8	1	1	-	1
Cancer care	-	2	7	2	-	-	-	-
Seniors and carers	-	1	5	1	-	-	-	-

(Summarised from Penman, Cohen et al. 2008)

A similar search of Medline up to December 2010 unearthed the following meta-analyses of yoga as a therapy for physical and mental health.

Table 4.4: Summary of Evidence 2007-2010

Study details	Summary	N=	Effect
Selfe and Innes (2009), USA	A review of eight studies found that they suggest that specific mind-body practices such as yoga, tai chi and qigong may help alleviate pain and enhance physical function in adults suffering from osteoarthritis of the knee.	267	2+
Sarris and Byrne (2011), Australia	A systematic review of 20 RCTS involving 8 CAM interventions found that there was evidentiary support in the treatment of chronic insomnia for acupressure, tai chi, and yoga, mixed evidence for	n/a	2+

	acupuncture and L-tryptophan, and weak and unsupportive evidence for herbal medicines such as valerian.		
Krisanaprakornkit et al. (2010), Thailand	A Cochrane review of 4 studies comparing yoga and meditation to other therapies for the treatment of ADHD could not draw any conclusions as to the effectiveness due to the small number of studies, the small sample sizes and the high risk of bias.	83	+/-
Innes et al. (2010), USA	A review of 21 papers representing 18 clinical trials from 6 countries found that yoga, meditation and Tai Chi may be beneficial for alleviating specific menopausal symptoms	n/a	2+
Ross et al. (2010), USA	A review of 10 studies comparing the effects of yoga and exercise seem to indicate that, in both healthy and diseased populations, yoga may be as effective as or better than exercise at improving a variety of health-related outcome measures.	n/a	3+
Uebelacker et al. (2010), USA	A review of eight clinical trials: 5 including individuals with clinical depression, and 3 for individuals with elevated depression symptoms, found encouraging results for the use of yoga as a treatment for depression. However the results are to be viewed as preliminary due to methodological limitations	n/a	1+
Birdee et al. (2009), USA	A review of 34 controlled studies published from 1979 to 2008 concluded that there are limited data on the clinical applications of yoga among the pediatric population. Most published controlled trials were suggestive of benefit, but results are preliminary based on low quantity and quality of trials.	n/a	1+
Lee et al. (2009), Korea	A review of 7 studies concluded that the evidence is insufficient to suggest that yoga is an effective intervention for menopause.	n/a	+/-
Aljasir et al. (2008), Canada	A review of five clinical trials found that short-term benefits for patients with diabetes may be achieved from practicing yoga. Further research is needed in this area to examine long-term effects.	363	1+
Smith and Pukall (2009), Canada	A systematic review of 10 studies including 6 RCTs noted some positive results from the use of yoga as an intervention for patients with cancer but suggested that variability across studies and methodological considerations did not allow for firm evidence of effectiveness.	n/a	1+
Galantino et al. (2008), USA	A systematic review of 24 studies evidence shows physiological benefits of yoga for the pediatric population that may benefit children through the rehabilitation process, but larger clinical trials, including specific measures of quality of life are necessary to provide definitive evidence.	n/a	2+
Yang (2007) USA	A systematic of 32 articles published between 1980 and April 2007 found that yoga interventions are generally effective in reducing body weight, blood pressure, glucose level and high cholesterol, the four leading risk factors of chronic disease, but only a few studies examined long-term adherence.	n/a	2+

The literature review of the evidence relating to the effectiveness of yoga in the treatment of many aspects of physical and mental health shows considerable scientific evidence for the effectiveness of yoga in the support of cardiovascular health. Further the research suggests that yoga can play a key role in the management of chronic diseases like diabetes, arthritis and depression (Yang 2007; Selfe and Innes 2009) and also in dealing with issues impacting on women's and children's health. There is some evidence to show that it can help in cancer care and respiratory and gastrointestinal health.

The research studies substantiate the support that yoga therapy can provide in clinical and neurological conditions and there is also an emerging body of evidence supporting the 'use of yoga and meditation interventions for mental health issues such as stress, anxiety and depression; primarily as adjunct therapies to conventional treatment or as part of a multi-disciplinary approach, and occasionally as stand-alone approaches' (Penman, Cohen et al. 2008:49). This evidence is particularly of note given the mental health issues that impact severely on the health of refugees. Further, none of the studies presented in the previous two tables reported any harmful effects from the yoga interventions, a point also made in the Yoga in Australia Survey (Penman, Cohen et al. 2008:76)

Yoga Therapy and the Health of Refugees

Yoga therapy is already being utilized as an intervention with refugees living in camps as well as with refugees resettled in Australia. The FORGE program runs yoga classes in the refugee camps at Kala and Meheba in Zambia (FORGE 2009). Yoga classes have also been run in 2010 at the Mae Tao Clinic, a hospital for refugees from Burma in Mae Sot, Thailand, as well as the Mae La refugee camp in Thailand (Durie 2010).

In Australia, yoga is or has been offered as a complementary therapy for refugees through the following services:

- Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), Brisbane.

- The Victorian Foundation for the Survivors of Torture (Foundation House), Melbourne.
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), Sydney.
- A Woman's Place refuge run by Mission Australia in King's Cross, Sydney. Clients include the homeless, ex-prisoners and refugees.
- The Multicultural Centre for Mental Health and Well-Being (Harmony Place), Brisbane.
- The Multicultural Development Association (MDA) Brisbane.
- The Hobart Yoga and Meditation Centre have been funded by the Tasmanian Department of Premier and Cabinet to run the 'help them heal: yoga for refugees' program in 2011.

(FASSTT 2006; QPASTT 2006; DPAC 2010; MA 2010)

However, much of the therapy for the mental health issues that refugees experience on their resettlement continues to be based on management through medication and/or psychotherapy and counseling (Aroche and Coello 2002; Shannahoff-Khalsa 2003; Forbes, Akturk et al. 2008; QPASTT 2009). As Forbes et al. (2008:87) explain:

Both approaches may be, in many cases, less than ideal. Medication management levies an arsenal of psychotropic weapons at the brain to improve the symptoms of anxiety and depression, without incorporating a more holistic view that takes into account the importance of clients' mental and emotional bodies. And while psychotherapy targets the mind and emotions, it traditionally is not equipped to address the body's physical experience of anxiety and depression. This may partially account for the typical time delay between insight achieved in psychotherapy and actual change in behaviours or symptoms.

Some of the talk-therapies utilized to work with refugee trauma include Psychoanalysis, Cognitive Behavior Therapy (CBT) or Dialectical Behavior Therapy (DBT) with an emphasis on the mind and the story (Aroche and Coello 2002; QPASTT 2006; VFST 2007). Not much emphasis is placed on the physical and body-based dimensions of trauma (Emerson, Sharma et al. 2009). As Dr. Bessel Van der Kolk, one of the pioneers of research into the psychobiology of trauma, states

‘words can’t integrate the disorganized sensations and action patterns that form the core imprint of the trauma’ going on to argue that treatment needs to integrate the sensations and actions that have become stuck, so that people can regain a sense of familiarity and efficiency (cited in Wylie 2004:5). Some of Van der Kolk’s neuroimaging studies have demonstrated that people process trauma from the body to the mind, and not from the mind to the body, implying that effective therapy would also need to function in similar ways and not just by words and language (Kolk 1994; Wylie 2004:6). He argues that:

traumatized individuals are prone to experience the present with physical sensations and emotions associated with the past. This, in turn, informs how they react to events in the present. For therapy to be effective it might be useful to focus on the patient’s physical self-experience and increase their self-awareness, rather than focusing exclusively on the meaning that people make of their experience—their narrative of the past.

(Kolk 2005:13)

This critique of talk-based therapies is also raised by Chan et al. (2006) who state that conventional posttraumatic interventions are limited by their dependence on the verbal communication of grief, not allowing for the multifaceted nature of the human coping process. They strongly suggest that reliance on a narrow set of therapeutic strategies or the expectation of a single form of coping from every client is very dangerous in terms of effective treatment. They go on to argue that non-verbal channels of exchange should also be sought, experimented with and consistently incorporated in post trauma interventions (2006:19).

Many of these communication issues inherent in talk-based therapies are overcome in yoga, as demonstration can become the major tool of communication. By copying, experiencing, exploring and self-regulating, the process of yoga learning can happen slowly and naturally (Saraswati 2010). Yoga practiced in this way can work towards addressing issues relating to the physical body as well as with thoughts and emotions, thereby narrowing the gap that is often found between insight and change in a talk-therapy process (Forbes, Akturk et al. 2008). However, the use of an interpreter in yoga classes with refugees is very useful to prevent any

miscommunication and to act as a source of cultural knowledge and understanding (Tribe 2005).

Cost is also an issue when comparing the present model of support for refugee mental health, using biomedicine and talk therapies, to an integrative model that incorporates yoga into the practice. Based on their 3-year follow up of people who had participated in a mindfulness meditation program as a complementary treatment for anxiety disorders, Miller et al. (1998) suggest that the long term benefits generated for very minimal cost have the potential for significant cost savings in mental health. The Harvard Medical School publication 'Yoga for Anxiety and Depression' also argues that yoga is a 'relatively low-risk, high-yield approach to improving overall health' (HMS 2009:4). Several scholars have pointed out to the ready availability and low-cost high-yield aspects of yoga (Shapiro and Cline 2004; Sherman 2006; McCall 2007)

Yoga therapy, along with other mind-body CAMs like Tai Chi and Qigong, can provide a unique way of meeting the physical and mental needs of a survivor of trauma, enabling them to connect in a gentle and friendly way with their own body and mind (Carter and Byrne 2003; Emerson, Sharma et al. 2009). It enables the healing to come from within and acts as a facilitative strategy by providing the nurturing environment in which the individual can rest and grow (Young 2001; Chan, Chan et al. 2006).

Some of the common mental health issues that are linked to the trauma that refugees experience include depression, anxiety, stress, memory and concentration issues as well as many of the other symptoms of Posttraumatic Stress Disorder (PTSD) (Bendfeldt-Zachrisson 1985; Fischman and Ross 1990; Silove, Tarn et al. 1991). Studies by Oken et al. (2006) and Woolery et al. (2004) as well as many other researchers demonstrated that, even analyzed within a Western scientific empirical-analytical framework, the practice of yoga positively affected cognition, mood swings, depression, anxiety and general quality of life (Kirkwood, Rampes et al. 2005; Pilkington, Kirkwood et al. 2005; Butler, Waelde et al. 2008; Descilo, Vedamurtachar et al. 2009; Emerson, Sharma et al. 2009).

Yoga has been offered as a practice that helps one calm the mind and body. More recently, research has shown that Yoga practices, including meditation,

relaxation, and physical postures, can reduce autonomic sympathetic activation, muscle tension, and blood pressure, improve neuroendocrine and hormonal activity, decrease physical symptoms and emotional distress, and increase quality of life. For these reasons, Yoga is a promising treatment or adjunctive therapy for addressing the cognitive, emotional, and physiological symptoms associated with trauma, and PTSD specifically.

(Emerson, Sharma et al. 2009:124)

Research in the area of yoga and trauma highlights the benefits that regular practice of yoga can bring to trauma survivors, such as refugees. In one study with the survivors of the 2004 tsunami in India, Descilo et al. (2009) compared one group practicing a yoga breathing course with another practicing yoga along with receiving psychological counseling and a third as the control group. All the yoga practitioners experienced a significant drop in their PTSD and depression scores after four days. They concluded that yoga-based interventions may help relieve psychological distress after mass disasters. Further, counseling provided no extra benefits over the practice of yoga by itself. Similarly, improvements in the physiological and psychological symptoms of PTSD were reported by Gerbarg and Brown (2005) in their research with Hurricane Katrina survivors who participated in yogic breathing courses. Telles and colleagues (2010) also, working with survivors of floods in India, found that a week of yoga could reduce feelings of sadness and possibly prevent an increase in anxiety in flood survivors a month after the calamity.

In one study of 16 women with PTSD, yoga participants were found to have a greater reduction in PTSD symptoms and the severity of hyperarousal symptoms as compared to those involved in Dialectical Behavior Therapy (DBT) (Emerson, Sharma et al. 2009). Carter and Byrne (2003) also concluded from their research with Australian Vietnam Veterans that yoga is an effective adjunct to psychiatric treatment for depression and PTSD and that it offered associated benefits including better sleep, better anger management, less medication and better quality of life as measured by patient and spousal satisfaction.

Yoga therapies have been shown to be effective for the treatment of anxiety and depression, disorders that are widely experienced by refugees (Bendfeldt-Zachrisson

1985; Kessler, Soukup et al. 2001; Pilkington, Kirkwood et al. 2005). Anxiety, depression and PTSD are associated with hyperactivity of the sympathetic nervous system and under activity of the parasympathetic nervous system. Both of these can be normalized, with heart rate variability as an indicator, using yoga breathing techniques (Gerbarg and Brown 2005; HMS 2009). In terms of anxiety, Gupta et al. (2006) in their study of 175 participants recorded considerable reduction in anxiety scores within ten days as a result of an intervention combining daily practice of yoga *asanas*, *pranayama* and relaxation techniques along with lifestyle advice. Butler et al. (2008) delineate a number of studies on the use of yoga/meditation for the treatment of depression and conclude based on the review and their own research that yoga shows promise to be clinically therapeutic for depression. A Cochrane systematic review of the effectiveness of yoga for treating anxiety and anxiety disorders also found positive results but referred to the usual issues of methodological inadequacies (Kirkwood, Rampes et al. 2005).

The effects of the practice of yoga on mood states such as tension-anxiety, depression-dejection, anger-hostility, fatigue-inertia and confusion-bewilderment were examined in 113 psychiatric inpatients at New Hampshire Hospital (Lavey, Sherman et al. 2005). The results showed significant improvements on all five of the negative emotion factors, suggesting that yoga practice was associated with improved mood and may be a useful way of reducing stress during psychiatric treatment. The improvement in mood states is also pointed out by Shapiro and Cline (2004) in their research on the impact of Iyengar Yoga on mood states.

Many refugees suffer from issues of stress and have many of the symptoms of an overactive stress response (Stoller and Krupinski 1973; Hollifield, Warner et al. 2002). While stress itself does not lead to illness, continued exposure to stress creates the conditions for an overactive stress response (Grossman 1983) which leads to health issues like cardiovascular disease, obsessive-compulsive disorder, depression, anxiety states, diabetes mellitus, some autoimmune diseases, colitis, irritable bowel syndrome and reproductive problems (Serber 2000; McCall 2007). Chronic stress response also leads to issues of chronic pain that in turn fuel further stress (PMTF 2010). The stress-related issue of chronic pain is a common health problem with refugees and others, such as war veterans, who have suffered trauma

(FASSTT 2006; VFST 2007; Sypek, Clugston et al. 2008). Yoga is already being used by individuals in the United States Army for reasons of health and well-being (AP 2006) as well as by the U. S. Department of Veterans Affairs for the management of pain and depression (VA 2008). This usage is further supported by the U. S. Army Surgeon-General's Pain Management Task Force report (2010) that recommends the use of yoga as one of the primary complementary therapies to be used for the treatment of pain, an application for which it is already being utilized at an informal level (Rhodes 2010). Yoga modulates the stress response by reducing the perceived stress and anxiety and decreasing physiological arousal in the form of heart rate, blood pressure and respiration (Gupta, Khera et al. 2006; HMS 2009). The efficacy of yoga in the reduction of an overactive stress response and its concomitant diseases and symptoms caused in a variety of settings and situations has been widely documented in a number of research studies (Serber 2000; Johnson and Kushner 2001; Young 2001; West, Otte et al. 2004; Chan, Chan et al. 2006; Bonura and Pargman 2009).

One of the key aspects of yoga that differentiates it from physical exercise and provides additional mental health benefits to the practitioner, is the practice of mindfulness or being in the moment. While the outward form of yogic postures appear similar to some forms of exercise, the practitioner is encouraged, through focus on the breath, to maintain a clear focus of the mind and through this are enabled to remain in the present without dwelling on the past or worrying and being anxious about the present or the future (Forbes, Akturk et al. 2008; Bonura and Pargman 2009). The breath techniques and the meditative techniques also help to cultivate this aspect of being in the moment. In terms of the health of refugees, Emerson et al. (2009:14) refer to the idea of trauma as a disease of not being able to be present and point to yoga as a way of being grounded in the here and now. Then 'the ability to cultivate mindfulness in the present moment while breathing, meditating, or practicing *asana* translates into the ability to practice mindfulness off the mat as well: cognitively, emotionally, and in interpersonal interactions' (Forbes, Akturk et al. 2008:90).

Yoga also provides the environment and the tools for self-empowerment of the individual. The various techniques and lifestyle of yoga, once learned, enable the participants to practice at any point of time, and without dependence on any person

or equipment (Young 2001; Forbes, Akturk et al. 2008). This aspect of yoga is of specific importance in the context of refugees. In addition to the different issues of the trauma experienced prior to resettlement, refugees settling into Australia face numerous difficulties of language, lack of familiarity with systems, minority status, loss of family and social networks, discrimination and hostility in the community, just to name a few of the issues. These can lead to intense feeling of guilt, anxiety, lack of trust, perceived loss of control, loss of purpose and loss of identity (VDHS 2008). Yoga can provide significant support to refugees in this environment by enabling them to play a more active part in the healing process and develop some level of independence in terms of their search for health and healing (Young 2001; Forbes, Akturk et al. 2008). It can help overcome past histories of helplessness and the inability to take action and provide them an opportunity to practice making choices and taking effective action that can promote their own mental and physical health (Emerson, Sharma et al. 2009).

While yoga can be of therapeutic benefit to refugees in Australia, it can also provide a model of self-care for professionals and volunteers working with refugees (Sisk 2007). Addison (2002) cites a number of empirical studies to argue that the psychological and emotional health of the therapist directly impacts on the outcomes of therapy. Unfortunately, as Garland (2010:91) states, in the case of many people in the helping professions ‘our striving for perfectionism as helpers, combined with distorted Judeo-Christian ideologies, causes us to become lost in the needs of our clients, foregoing our own’. Yoga can provide a self-directed system of healing for professionals working with refugees, using their own practice to help with their own physical, mental, emotional and spiritual well-being as well as helping them to provide the best possible outcomes in the therapeutic process (Garland 2010).

Summary

Yoga refers to a joining of the individual consciousness and the universal consciousness or to the bounded reality of the human’s experience of body, mind and spirit. At the practical level, the term is widely used to refer to that group of practices, originally from India, which helps develop harmony in the body, mind and spirit. The chapter provided a background to the development of yoga, both in India and globally and reviewed the differentiated approaches to health between yoga and the allopathic (biomedicine) perspectives. The diverse schools of yoga philosophy

and practice were explored. Drawing on global studies the chapter pointed out that yoga was increasingly being practiced in Western societies for a range of reasons ranging from healing, pain management, exercise, recreation and spiritualism. However, it was identified that yoga in the West has a stronger focus on the physical body. The chapter makes a differentiation between yoga and yoga therapy. The latter is a modern phenomenon resulting from the encounter between Western medicine and science and represents an effort to integrate traditional yogic concepts and techniques with Western medical and psychological knowledge. The benefits of yoga therapy in addressing a multitude of health problems, evidenced from Western scientific studies, were provided. The chapter concluded with a review of the benefits and limitations of yoga therapy for refugees. The next three chapters provide the findings of this study followed by Chapter 8 that analyzes the findings and explores future directions.

Chapter 5: Themes - The Refugee Experience and Health

The key research question in this thesis looks at the role that yoga therapy, as a complementary therapy, can play in responding to the complex health issues of refugees settling in Australia. Towards examining this clearly within its context, I began by looking at what these health needs were and what were the key factors that impacted on them. The understanding of the health needs of refugees that emerged then enabled the discussion of the effectiveness of the present health system in responding to these needs, details of which are in the next chapter.

The health of refugees in Australia is a complex issue and is impacted on by a number of factors (Beiser 1991; NCTSN 2005; VFST 2007). The first major factors are the issues of trauma, loss and dispossession experienced at the time of leaving their homes and fleeing to refugee camps or other places of relative safety as well as during the times in these camps. These are times when people are vulnerable, helpless and dependent and often without support structures of family and friends. These times can be periods of long-term stress and trauma and lead to long-term impacts on the health of refugees (WHO 1996; UNHCR 2005). Another factor is the resettlement process in a new country, where issues such as language, racism and discrimination, loneliness and alienation and loss of coping mechanisms and support structures can also lead to intense stress experienced by the individual, the family and the community (Marshall, Schell et al. 2005; VDHS 2008; RCOA 2010). And finally there are the normal lifecycle stages and personality/family issues that everyone experiences but can be more difficult to negotiate when already traumatized by the earlier factors (Aroche and Coello 2002; RTTF 2003). All of these factors cause refugees to be prone to acute as well as chronic issues of health that in turn impact on their ability to settle successfully in Australia.

The chapter presents the themes that emerged from the interviews relating to the refugee participants' experiences of leaving their homes, often in violent and dangerous circumstances. It goes on to explore their experiences in travelling to place of temporary safety, often in a refugee camp in a country neighboring their home country and their lives there. Finally it examines the themes emerging from the

settlement process in Australia and also reports on the chronic health issues that the interviewees are still dealing with.

Trauma of the Refugee Experience

Most, if not all refugees experience emotional trauma, violence and deprivation in the process of fleeing their homes, a process that involves the loss of homes, livelihoods, loved ones and often involves the experience of disease, malnutrition and starvation (Aroche and Coello 2002; Babacan and Gopalkrishnan 2005; UNHCR 2007). This is also reflected in the refugees who resettle in Australia where 7 out of 10 refugees who go through health assessments report having experienced psychological or physical violence of some kind (VFST 2007). In this study, all fifteen refugee interviewees had experienced violence and trauma before coming to Australia. For most of them, this began in either before or at the point that they had to flee from their homes due to violence or the fear of violence. Though the purpose of this study was not to explore the traumatic experiences of the women refugees, several of the participants wished to share their stories at different points of the interviews, and some of these stories are presented in this chapter. One of the women who shared her story was Dah Gay who spoke about the day she left her village in Burma:

when I was small, before thirteen years old, things like that I've never experience, when I was thirteen years old I saw the Burmese military shot somebody dead in front of me...I saw they shot the person and then chopped the neck off and put them on the post, just the headAnd then the body was put on the ground near the stump where they were putting the head and then when I saw that I fell over, I could not move any more. My older sister, when they saw that they managed to move so they ran away, where as I was, I fell over and I can't move anymore and later they came back to get me. Where I was, I can't cope anymore and I left the place...the Burmese soldiers go to my mum and hit the head with the gun...they killed my family's animals to eat...like cows, buffaloes.... They took everything...our clothing and everything...there's winter time and my older brother came back that time and he was so cold but there was nothing in the house. He was so upset, feeling miserable and devastated. All our rice, all our foods were taken away.

Most of the interviewees had lived in villages or small towns from where they were driven by fighting and violence. The perpetrators included the military, as in the cases of the Karen people in Burma, Tamils in Sri Lanka and Kurds in Iraq, as well as militia groups as in the Sudan, Rwanda and Afghanistan. For some of the participants, especially those from cities, it was not general violence but direct persecution aimed at them for their views or actions. These included Naw Wah, who was in danger of being arrested for her father's media work on the behalf of the Karen people, Mahtab for her religious faith, and Neda for her Western clothes and refusal to cover her head.

Several of the interviewees had witnessed torture and killings of relatives. Shalini was one of those who had experienced violence at the hands of the Sri Lankan military but had only this to say as a response to her experiences:

Since I arrived here, I have tried to forget about those bad experiences....I only want peace for everyone.

Violence, loss and dispossession were a reoccurring theme in all the stories told by the refugee interviewees. Neda fled a city in Afghanistan to a refugee camp in Pakistan, but lost contact with her sister and her brother-in-law, who were kidnapped and had six of their children killed by the Taliban. Musu spent eight months in jail in Liberia before escaping to Guinea. Kesi witnessed wide spread violence in Sudan and was in fear for her life before she was able to escape to Kenya. On a similar theme, all the participants in the refugee focus group spoke about the fact that they had experiences of trauma and loss as they had to flee their homes. For many of the interviewees, the experience of this loss continues even now as, for example, they get news of relatives killed or missing in their home countries.

Escape to refugee camps was a common thread through the narratives of many of the refugee interviewees. All of these refugee camps were based in developing countries, emphasizing the statement of the United Nations High Commissioner for Refugees that the responsibility of hosting almost half the world's refugees is shouldered by developing countries (UNHCR 2010). These camps include those in Thailand as the destination of the Karen refugees, while camps in Kenya became home to refugees from Southern Sudan, Pakistani camps for those escaping from Afghanistan, and Turkish camps for those escaping from both Iraq and Iran. Not all the interviewees

settled in camps. There are no refugee camps in Cairo though the UNHCR office to process the refugee applications is based there, so Hasina and her family had to manage in temporary shelter in the city outskirts while their application was being processed. Musu had to live nine years in a house in Guinea, while Shalini spent one and a half years in a detention centre in Australia before her application to be recognized as a refugee was finally approved.

The journeys to the camps or to other countries were very traumatic in themselves. For a few it took years to reach a place they could settle in and place an application for a humanitarian visa to Australia, as with Josephine who moved for seven years from country to country after she escaped from Rwanda, until she reached safety in a camp in Zimbabwe. The harsh terrain as well as the ever present danger of armed enemies was spoken of very often, as with the journeys through the jungles of Burma and the deserts of Western Sudan. Some of the interviewees were made to work as forced labor by militant groups. The suffering as well as the sacrifice is exemplified in Dah Gay's narrative:

On the way I've been captured by the Burmese soldiers and we have to be the porters and they've been dragging us around. While I was a porter, there's been fighting and bullets comes here, there, and everywhere and people come and go (running) and for me I can barely walk and I fell over....We were running through the jungle, and we only have 3 cups of rice to last us for two to three weeks and my older brother and sister...they didn't eat much...they try to eat what they can get from the jungle and they only feed us the rice.
(Dah Gay)

The camps themselves were a mixed set of experiences for the women. For some of them, the camps represented peace and protection from violence. Mu Dah spoke of the eternal vigilance in the village she lived in prior to the camp, where a year of hard work in crops and housing could be destroyed in a day by incursions of the 'enemy'. She stated that in the camp 'it's not so bad'. For others, the camps were not as peaceful as they are hoped them to be. Paw Say described the repeated visits of the militia to the refugee camp, where they fired weapons and generally terrified the residents. She compared the peaceful summers in Australia to the fearful ones she experienced in the camps. Kesi recounted the terrible fear she experienced as a

woman in the Kenyan refugee camp as that there were a number of armed gangs in the camp, and a lone woman was often the target of sexual assault. As Naw Wah said:

If you listen to the name 'the refugee camp', it's already said it. It's not a place where people want to be there, but you have no choice.

Camp life was a struggle for many of the participants to balance their need for safety with the economic need to provide for their families. Kesi made a living selling tea in the Kenyan camp but had to be very careful of the armed gangs, even though she had her husband to protect her. While the Turkish camp was relatively peaceful, the harsh winter and the lack of basic necessities made life very difficult for Zainab. Though it was against camp law to leave the camps to seek work, several of the Karen interviewees had to leave children at the camps while they went into Thai towns to find jobs and earn some money. They were constantly shadowed by the fear of being arrested by the Thai police, as well as sadness at leaving their children back in the camps, but continued to work to earn a little money for their families.

Health needs were also an issue in the camps, where the medical infrastructure could only deal with basic issues. Mu Dah spoke of the time she found a lump in her neck and worried about it being cancer. She could not get it checked in the camp and was so anxious about the possibilities of cancer that she began to consider suicide by hanging. It was only when she got to Australia and had tests to show the lump was benign that she was relieved of that source of stress. Musu had a problem with internal bleeding during her time in Guinea and was lucky to find a friend with contacts within the Médecins Sans Frontières hospital and had an operation to deal with the problem. Several of the other participants spoke of the hardship they had experienced dealing with even relatively minor health issues in the camps.

The struggle and stress of the refugee camps was not just over a short period of time. All the refugee interviewees spent considerable periods of time in refugee camps or in temporary locations before they got through the application process and were granted Humanitarian visas to Australia. The shortest stay was a year and a half for Mahtab in Turkey while others ranged from seven years for Josephine in Zimbabwe and nine years for Musu in Guinea to twenty years for Dah Eh in a camp on the Thai-Burma border. Not all these stays were uninterrupted, as in the case of Dah Eh who

went back to her village to get married and stayed there for four years before her husband was arrested and she had to flee again.

The stories that the refugee participants told of their journeys were those of hardship and suffering over extended periods of time and yet are a testament to resilience as almost all of them continued to display a remarkable sense of positive feelings for the future. Remarkably, none of them spoke of emotions like blame or anger for the situation that they were in and most spoke of life as getting better in Australia.

Settlement Issues

Aroche and Coello (2002) have delineated the challenges faced by refugees in their country of resettlement as (1) torture and trauma issues (2) exile, migration and resettlement issues and (3) the normal life cycle stages and personality/ family issues. The first two sets of experiences are unique to the refugee experience and can place the individuals, families and the community in a vulnerable position in the host country as well as leave them less able to utilize their internal resources as well as the external opportunities. These first two sets of factors also limit the ability of refugees to negotiate the stages of the life cycle that may appear normal to many people (Aroche and Coello 2002). While some of the experiences prior to reaching Australia are described in the previous section, this section explores the narratives of the interviewees after they reached Australia and presents some of the themes that emerged.

Language issues

The ability or inability to speak English fluently, and its personal, economic and social consequences, was a theme that was often brought up in the interviews. Refugees settling in Australia are offered up to 510 hours of English language classes under the Adult Migrant English Program (AMEP) funded by the Department of Immigration and Citizenship (DIAC 2010), and a further program of up to 800 hours under the Language, Literacy and Numeracy Program (LLNP) funded by the Department of Education, Employment and Workplace Relations (DIAC 2010). All the refugee participants in their early years of residence were either in the AMEP program or the LLNP program and had to communicate with the help of an interpreter. Musu was one of the few who was fluent in English and did not need an interpreter for the interview. She explained that this was because she came from

Liberia which has been an English-speaking country with a strong American influence since 1980. Shalini was also fluent in English as she spoke it to some extent before she came to Australia and had been here for long enough to develop fluency. Similarly, Mahtab came to Australia with some knowledge of English and was able to communicate without an interpreter.

Many of the participants spoke of the pressure and stress that they experienced because of not being able to speak English fluently. As Si Poe said:

For me, living here in Australia...since I arrived here...we have so many opportunities...we can go and come freely. We don't have to worry or scared anymore because the government is good. It is great. However inside we are feeling something...because we don't know the language at all. We have to start studying and learning so it is very difficult even though we get to live nicely. This is the main problem that I face.

The lack of English fluency also created issues with getting jobs and developing some level of economic self-sufficiency. Hasina reflected on the tension she experienced each time Centrelink staff or someone official rang up. She talked about how hard it was, not being able to understand what they were saying and the worry and pressure that lack of understanding caused. Several interviewees spoke of the arrival of letters as another source of worry and fear again particularly because of the length of time it took to find someone to translate the contents. This dependence on others for reading letters as well as for filling in official documentation was also an issue for several of the participants.

Neda reflected on this anxiety and fear and argued that some of the illness that refugee women experience was due to this stress when she said:

I cannot speak the language...like many from my country...face so many problems...If we can speak English I am sure we will be healthier.

Htoo Say mentioned this issue while she was writing her name in Karen on the interview consent form saying, 'Writing my own name in Karen is a lot better...not so stressful...doing it in English is more...all my energy gone'. This was reiterated by Hasina who stated that if they were able to speak English and communicate

fluently half their pressures and worries would be reduced. Her hope was in her children, that they would grow up with English fluency and then things would get better.

One of the medical practitioners, Behnaam, who spoke a language that is also spoken by refugees from Afghanistan, reiterated many of these issues when he spoke about English language difficulties among his refugee clients.

In Australia they have a language barrier. Probably it's not easy for them to learn a new language. A lot of them haven't been educated formally. They haven't had the chance. They haven't gone to school, or if they have, they have gone for one or two years only. So even their - I mean, they're illiterate even in their own language...They have lost the confidence to come out. They wouldn't talk to people because they don't know what to say. They cannot communicate, so they depend on their kids. Initially they - the kids - don't speak English as well, but probably after one or two years the kids can speak English okay, then the kids become the interpreters for mum or dad.... It would be very difficult, and that's why they come [to me] from a long way, from a long distance. They come a long way just to be able to express themselves.

Most of the participants were going through the formal processes of learning English, but for almost all of them these were inadequate in terms of developing fluency in the language. One of the service providers (Kira) spoke of a way towards working with this issue while relating it to the alienation and lack of engagement with the broader community. She argued that many of the refugees have only had the formal English classes to engage them and that there needs to be other processes to bring refugees together and enable them to practice their language skills in a more informal setting. She spoke at some length about this possibility as

At the moment, you know, people are crying out to attend their English classes and to have more hours made available. It's only three days a week for what translates to be about 15 hours, and the rest of the time, you know, people are saying 'We really want the opportunity to speak English' and you know, the kind of project that gets to integrate those practical aspects,

conversational English meets opportunity to talk about my health and my community, to learn a bit, to share a bit, meets job outcomes as in 'When I've had the opportunity to participate in that activity I then can facilitate that community and be empowered'. You know, like a kind of project that can integrate both the practical aspects of people's needs, having a sense of purpose through being employed or being trained or with the release that comes from sharing one's history but also learning.

The issue was also raised at the service provider focus group, and the consensus was that the hours of English classes provided were inadequate. They pointed out that more hours provided per week would enable refugees to settle into Australia quicker and be able to engage with the systems more productively.

Racism and Discrimination

There is strong evidence to suggest that refugees in Australia often face racism as well as discrimination in the public arena and in the workplace (Colic-Peisker and Tilbury 2007; VicHealth 2007; Babacan, Gopalkrishnan et al. 2009; Correa-Velez, Gifford et al. 2010). These experiences of racism and discrimination have significant impacts on the health of refugees and have been shown to contribute to the mental and physical health issues that have been identified within the refugee communities (Beiser 1991; VicHealth 2007; Ellis, MacDonald et al. 2008).

Interviewees from the Brisbane yoga group had diverse opinions about the attitudes of people in Australia. Musu was particularly critical of the attitudes of hospital staff that would not listen to her and dismissed her views with disparaging remarks like 'Oh these Africans are like that...'. She stated that she was often profiled because of her African background and targeted for diseases like tuberculosis. Neda also reported negative attitudes from the wider community in Australia and reiterated that this was the cause of her stress and anxiety. Mahtab was particularly angry when she reported that her children were being bullied at school because of their backgrounds.

Shalini was not sure that she had experienced racism but many of the incidents that she related were suggestive of discrimination in the workplace. Josephine, on the other hand, argued that there were no issues of racism in Australia and that she was made welcome by the wider community, even if she could not communicate with them very well due to language difficulties.

None of the Karen participants spoke of issues of racism during the interviews. One of the Melbourne interviewees, a trained interpreter, expressed her opinion that the reason for not speaking about racism was a cultural one as she pointed out that:

One thing about the Karen people we always love peace... so we don't usually say something bad about anybody... that's why they kept that in their hearts... and not expressing out... but as a group of women and as a group of chatting and talking about your experiences... everyone will throw in their experiences... I know that a lots of the people they been throw with the egg, they being said bad word to them at the station while walking down and finger showing up... this kind of things. For the Karen people they are very simple... they just take thing easily... if they been yelled at... they will be sad... they don't know how to make their shield outside the body to protect this kind of discrimination (Ler Say).

This view was verified during the refugee focus group, when some of the participants who had not mentioned racism in their interviews spoke about some of racist attitudes they faced in Australia. As an example they discussed that there was a feeling among members of their local church that the Karen people did not want to work, were lazy and that the Karen refugees had come from a peaceful country just for the economic opportunities in Australia, or in other words, to take people's jobs. The discussion from there was on the lines that people who thought like that needed to be forgiven and given understanding, that they were misinformed, and that the Karen people were lucky that the Australian government allowed them to come to Australia. The discussion closed with the reflection that if their country was peaceful again, they would love to go back and live there. The focus group also discussed the impacts of racism on their health and there were differing views on this. Some participants stated that there was no connection between health and experiences of racism, while several of the others argued strongly that the attitudes of others did have an impact on their health using phrases like 'you will feel low and suffer' and 'you feel small all the time'.

The experience of racism and discrimination was also spoken about in some of the interviews with the service providers. Ler Say talked about an incident where she was interpreting for a friend who was in hospital for her delivery. The doctor was

extremely rude and aggressive to them and said ‘how do these kinds of people manage to get here? What are they doing here?’ She was shocked by the incident but did not make an issue of the incident because she herself was new to the country at the time. She considered that even when people were not overtly being racist, their body language and reactions were quite telling. This was also discussed in the service provider focus group. No consensus was reached, but the majority of the participants in the group maintained that racism is an everyday experience for many of their clients and that it did have impacts on their health. 9/11 came up in the discussion several times as an example of a ‘crisis point’ after which the overt racism that people who were visibly different were targeted, such as in the case of covered Muslim women. One participant did not agree with the other participants and asserted that the cases of racism were being overstated.

A broad range of experiences of racism was referred to by Neva, a complementary therapist who had worked for many years within a torture and trauma service, who stated that the experience differed based on how visibly different the particular refugee group looked. As she explained it, many of her refugee clients were of European appearance and did not experience the same level of racism that those of Middle-Eastern appearance did. She recounted several instances where her clients, after 9/11, could not come in for therapy even if they lived close by because of fear and feelings of vulnerability. They were being spat on and harassed in public. She also recounted the story of a Somali woman who was attacked because she was perceived as a terrorist just after 9/11. These and similar incidents were not restricted to the metropolitan cities of Australia. In the context of a regional town, Kira, a service provider, stated that she often vicariously experienced racism, just accompanying refugees or refugee families to appointments, and also especially dealing with some of the doctors and nurses in hospital settings. Sometimes, she considered that she experienced the racist attitudes more than the newly-arrived families because they were often unaware of what was being said or unable to accurately interpret the body language.

Despite all of these issues, many of the participants spoke of Australia and Australians with great fondness. Ler Paw had a particularly special vision of Australia as a country of resettlement saying:

When I applied to come to Australia, people told me that Australia is an island and in my head I was thinking like... yes it is island...probably like Noah's time...like in the bible that surrounded with water that animals...and the animals were taking care of by families really well. Then when I got to this country, it is a bit like that. And like in the bible where people are very supportive and love animals and all these things...this is a really blessed country that I'm in. In this country, the government, the teacher, everybody so helpful and supportive and not racist so I think this is a really blessed country. For me I think that this country can never be destroyed. It's not a country that do bad thing so I think that God will look after this country.

Alienation and loss of social networks.

The initial period of any migrant's settlement into a new country is often marked by the loss of social and family networks (Babacan and Gopalkrishnan 2005). With the refugee experience, this is exacerbated by the loss of the resources to develop new networks and thus can be a period of intense alienation and loneliness, especially for refugees coming from communal cultures (VFST 2007; VDHS 2008) whereas Mu Dah said 'over there everybody struggle so each family look after each other'. The majority of the interviewees spoke of this sense of sadness and frustration at the lonely environment. As Neda said:

I am here for seven years now and I have no friends. Because I am from city I do not cover [with a veil] and other people from my community do not like me... I am alone here, very stressed and bad health.

Some of them spoke of repetitively doing activities like cutting the grass on the lawn even when it wasn't needed, just to be active. The key focus of all the interviewees who were in the initial stages of settlement was the English language class, which provided an opportunity for them to meet others from similar backgrounds. Several of the participants spoke of the paucity of social occasions when they could get together and interact with others of their communities and also the rental arrangements, which often meant that they could not get a house close to others of the same background or mix with them easily.

This loneliness and alienation was not only expressed by the refugee participants. One of the complementary therapists, all of whose clients were of refugee background, spoke of the stories shared by her clients:

People would say to me that they were just very lonely, and that although they knew people from their own community, what really absolutely - they couldn't stand about Australia is that everyone's in their own house, behind their own fence. Children don't really play in the streets. There isn't a cosmopolitan feel out in the streets. In their countries of origin it's so much more of a public life. People are so much more outdoors, or you know, they would say, "Like, I don't even know my neighbor. You know, like, where I'm from its unheard of. Everyone knows their neighbor and talks to their neighbor". So people talked about being very lonely and isolated. (Neva)

Much of the literature focuses on the experience of refugees in the early stages of resettlement, essentially within the first year of settlement into the host country and, as many of the participants in this study were in their initial periods of settlement, their narratives reflected the experiences of this period. However, studies have shown that the impacts of trauma, as well as the loss of social networks, language issues and job issues can extend well beyond the initial period (Sabin, Cardozo et al. 2003; Marshall, Schell et al. 2005). Some of the participants who had been here for longer periods of time, such as Shalini, had been able to establish their social and professional networks in Australia. Others, like Neda, were unable to break out of their loneliness in spite of being many years in Australia.

Almost all the service providers and three of the medical practitioners spoke about the issues of loneliness and alienation as well as the long term nature of these issues for many of the people that they worked with. Rez spoke of her experience with running an exercise/yoga group for refugee men. She reported that many of the men who came to classes came with feelings of anxiety and depression. She said that even those men who had been in the country for a considerable period of time, up to twenty years, came to the classes with feelings of isolation and alienation. She argued that, though there is often an assumption that refugees are able to establish their networks after some time, the refugee experience makes it very difficult to find jobs, to reconnect with one's identity and to establish new networks. She asserted

that these factors had a big impact on people's lives. Other service providers spoke of clients coming back to them after being referred on, just to have a conversation and perhaps a sense of connection and a feeling of engagement. They also reported a distinct difference in this issue of loneliness and alienation depending on the individual levels of education and English language fluency prior to coming to Australia, with the more educated and/or fluent individuals making friends and social networks extremely quickly as compared to those not so fortunate. Many of these issues of loneliness and isolation were also reiterated in the focus group for service providers where the consensus was that more opportunities were needed.

Health Issues

Refugees experience a complex cluster of conditions and intense trauma, often for lengthy periods of time, leaving them at great risk for a number of physical and mental disorders (Bendfeldt-Zachrisson 1985; Kiesler 1999; Silove 1999). At the physical level, many of these are related to infections, nutritional deficiencies or physical injuries, all of which are treated within the medical system (Olness 1998; Tiong, Patel et al. 2006). However, even at the physical level, many refugees present with a number of physical symptoms that are reflective of mental distress, sometimes known as somatization, symptoms that include chronic issues of body and abdominal pain, insomnia, breathing difficulties, skin and menstrual problems and palpitations (WHO 1996; NCTSN 2005). These physical symptoms are often chronic in nature and can be identified many years after the experiences that precipitated them (Minas, Szmukler et al. 1988; Sabin, Cardozo et al. 2003). As the interviews in this study were with refugees who had self-selected to join the yoga classes, I was aware that most of them would have some of these chronic physical issues that they wished to deal with using yoga. Nevertheless, it was a surprise when every one of the refugee interviewees reported chronic health issues and most of them spoke of a complex set of chronic physical complaints that they had been trying to resolve using the medical system, before they had turned to alternative therapy for treatment. Mu Dah described the process of the symptoms and their causes as:

The sickness is caused by things that we've experience from the past...we still have horrible feelings within our hearts that are not nice...then we get neck and back pain... we think a lot and cannot sleep at night time so it becomes heart disease... some have blood pressure... some cannot breathe

properly...becomes joints pain and cannot sleep... lower back (waist) and whole body ache... all of these things that people experience.

While the issues were reported as a basket of health issues experienced by individuals, I have separated them out into separate symptoms for clarity in reporting.

Chronic Pain: Thirteen of the fifteen refugee interviewees complained of issues of chronic pain often in combination with other symptoms. The pain issues included headaches, neck and back pain, and pain in the arms and the legs. In some cases, the pain, was of such intensity that they it restricted their lives to a very large extent.

This one - because my muscle, all my muscle very sore and sometime I'm very upset and all my body very - muscle all sore and I can't control my brain, and all the time I'm dizzy. And this one doctor, writing, said to me "This one make to sleep and you feel relaxed". That's why I take this medication (Neda).

Several of them spoke of the need to keep warm as a way to help the pain, but also spoke of unhappiness, anxiety and stress as causing their pain. A common phrase that emerged in the interviews was ‘thinking too much’ as a cause of illness. All of the interviewees who complained of pain had been to medical practitioners for these issues and many had undertaken tests like X-rays and ultrasound scans without being able to resolve the pain. In some cases, medication had been used to alleviate the symptoms. Much of the pain experienced by the interviewees did not have a cause in medical terms and as one of the complementary therapists said, ‘that is a typical client, people with unexplained symptoms, especially unexplained pain’ (Neva).

Breathing issues: Nine of the participants reported problems with feelings of ‘not enough breath’ or breathing difficulties. Paw Say said she had to be hospitalized the day after landing in Darwin because of breathing difficulties and that the cause was not known. She went on to say that:

My heart beats really fast. I don't think of anything but my heart beats really fast and I feel like I don't have breath enough.

Mu Dah spoke of the difficulties in breathing and their causes, in the context of the relief she found with yogic breathing as:

the things that are inside you... you feel like you don't get enough breath... and when you take a big breath, it helps... all the bad things from inside disappeared... this is really good for us.

Like Mu Dah, most of the participants connected their breathing difficulties with internal feelings such as anxiety and stress. Zainab ascribed her breathing difficulties to

... when I am afraid. I remember many things and feel bad and breathing is difficult. I think too much and I feel really tired then.

Insomnia: The majority of refugee interviewees, fourteen of the fifteen, had issues with sleep deprivation. There was a common thread here again of 'thinking' as the cause of sleeplessness, sometimes accompanied by pain, heart palpitations and/or feelings of breathlessness. Many of them spoke of reoccurring nightmares. Some of the interviewees also reported sleep issues as reflected in feelings of being exhausted on waking in the morning. Mu Dah reflected on the intertwining of issues that caused her insomnia and the way in which a mixture of modalities helped her to deal with her problems:

Because in the past, we have headache, neck and back pain... we don't know what to do and don't know who to lean on... We went to the doctor but they can't find anything... you come home, you think, you can't sleep either. Later I have been called and treated with natural therapy...we get massage... oil massage. And we have to do yoga... all the exercises and movements are very useful for me. This is my person view because in the past I cannot sleep at all.

Physical tremors: While many of the interviewees spoke of physical shaking and tremors, three of them spoke of this problem as so intense that it impacted on their everyday lives. Neda said that the intensity of trembling in her hands was so great at times that she dropped and broke several things in her home. Ler Paw associated her trembling to fear saying:

Whenever I go to Centrelinks, my legs and hands always shake. I hope that they don't say anything to me. Whenever I go I pray all the time.

Palpitations: Eleven of the participants reported episodes of heart palpitations. Some of these were connected to situations of stress such letters or visits to Centrelink but others reported episodes in everyday situations, often connected to ‘thinking too much’. These were often accompanied by feelings of breathlessness.

Skin Problems: Four interviewees spoke about itching and skin allergies.

Menstrual Problems: Two interviewees spoke about having irregularities in their menstrual cycle and one other spoke of menopause as the cause of her illness. This issue is likely to be underreported and that of sexual problems not reported at all as the participants were all female and I, as a male, was the interviewer.

Flashbacks: Two of the participants said that they had had episodes reliving their traumatic experiences. Ler Paw described her experience as

Not long ago, I was told that the Burmese shot my one of my relatives. The minute I hear that I get so anxious and so worry that I can hear my heard pounding so much and I don't feel well at all. I don't feel good at all... During that time, the memory from the past came back... things that I faced in the past... about death, killing... I saw the Burmese military tortured and killed a woman who had asked her husband to run away from the Burmese military. I could see all those in my memory... So I got upset more and more.

While what she said connected this episode to a specific event, another participant said that her attacks did not necessarily have to be triggered by an external event.

Cognitive Issues: Several of the participants spoke of memory loss and forgetfulness, of not being able to remember mundane things like their own home addresses and telephone numbers. Some of them also reported a loss of the sense of the present, of where they were at that point in time, and of being disoriented to the point that they were in physical danger. One interviewee said that there were occasions when she had crossed roads without being aware of where she was and was grateful to the drivers who had stopped to let her by.

Stress, Anxiety, Depression and PTSD: Scholars reporting on the mental health of refugees point to the prevalence of posttraumatic stress disorder, anxiety disorders and depression as some of the main mental health issues that refugees face (WHO

1996; VFST 2007). The intense and long term exposure to stressors in the world around them can lead to chronic and long term psychological sequelae and distress that continue even when there is no direct threat. These in turn lead to a spiral of physical and psychological complaints (Marshall, Schell et al. 2005; VFST 2007). Almost all the interviewees in this study spoke of intense feelings of anxiety and chronic stress, and a few spoke of depression, in the context of explaining the causes of their symptoms. Phrases like 'too much worry' 'thinking too much' and 'made me very sad' were commonly used in conjunction with descriptions of intense physical symptoms, as pointed out earlier, that seemed to fit much of the symptom criteria of PTSD. Several of the participants also spoke of deliberate self-isolation in terms of actions like locking oneself away for long periods of time.

This range of issues that refugees suffer from was also confirmed during the interviews with the different medical practitioners. Behnaam, a general practitioner with a number of refugee clients, summarized the health issues as

Probably the number one thing was headaches, anxiety, poor digestion and stomach pains, lower back pain, Skin problems. Definitely skin problems. Menstrual problems for women, that was your typical thing. Obviously, you know, disturbed sleep. I mean, that was just about everyone couldn't get a good night's sleep. Loss of appetite, yeah. I also had, I guess, people with more unusual symptoms. There was one woman who went completely bald. All her hair dropped out and western medicine basically said to her, you know, "It's finished. There's nothing left", but her hair came back...High cholesterol, high blood pressure, heart palpitations, real typical symptomatic stuff.....Well a lot of them suffer from anxiety, depression, PTSD, post traumatic stress disorder.

A similar combination of symptoms was also spoken about by Ava, one of the yoga therapists, who had worked with refugees for many years. She reported that

Like a lot of them report body pain, headaches. I'd say 95 per cent of them have problems with sleep, particularly more newly arrived. They talk about dizziness. I think that's a sort of cultural term and I think - I'm trying to work out exactly what they mean by dizziness, but I think a lot of them mean anxiety actually. So - because it can tend to go along with feeling weak and tired, so that is like this sort of cluster of symptoms. And a lot of them talk

about their blood pressure, but their actual blood pressure's fine so I think that's again part of the way they understand when they feel out of sorts. Yes, so those were symptoms, and yeah, a lot describe sort of, neck and shoulder pain, and back pain, and pain in the legs, and pain all over.

The range of health issues described by the participants reinforced the delineation of mental health issues in the literature especially in terms of: cognitive symptoms like disorientation, memory disturbance, and poor concentration; psychological symptoms like anxiety, depression, self-isolation and social withdrawal as well as; neurovegetative symptoms like lack of energy, insomnia and nightmares (Silove 1999; NCTSN 2005). The problems the participants spoke of were mostly not of the intensity that they would require hospitalization, but were acute enough to have a major impact on their everyday lives, especially in terms of gaining employment or of engaging fully with their families and the community.

Summary

This chapter presented the themes that emerged from the refugee participants' stories from the point that they had to flee from their homes in fear of violence to the camps in which they sought refuge in most cases and also when they finally reached safety in Australia and began the next journey of settlement in a new country. The trauma that is a part of this journey was explored because of the long-term impacts on the health of the interviewees. Some of the issues raised by the participants that impact adversely on the health of refugees in Australia, such as issues of language, racism and loneliness were also examined in this chapter. Finally, the chapter closed describing the chronic nature of the health issues of the refugee participants, including a range of symptoms such as pain, palpitations, breathing issues, insomnia, tremors, skin problems, and menstrual problems, flashbacks, cognitive issues, anxiety, depression and PTSD. This discussion provided the basis to examine the extent to which the present medical system was able to respond effectively to the health needs discussed and the role that CAM approaches could play in supporting these needs. The next chapter examines the findings from the experiences of refugee participants with biomedical models of health in Australia and documents what barriers they faced in addressing their health needs. The next chapter also examines the experiences (from country of origin and Australia) of the experiences with CAMs.

Chapter 6: Themes - Health and Health Systems

The health issues of refugees settling in Australia continue to be largely supported through biomedical structures of hospitals, clinics and specialized psychological and psychiatric services (FASSTT 2006; QH 2008). However, complementary therapies are increasingly finding a role within meeting their health needs (WHO 1996; FASSTT 2006). This chapter presents the identified themes relating to the refugee interviewees' experience of the biomedical system, both in their home countries and in Australia, as well as their views of the extent to which their health needs were met by this system. To examine the extent to which complementary therapies in general can play a part in supporting the complex health needs of refugees, their views and experiences of complementary therapies, both in their home countries and in Australia, are explored. These themes are also examined in the context of the views expressed by the medical practitioners, complementary therapists, yoga therapists and service providers. This exploration of the larger context of complementary therapies in general leads into the analysis of yoga therapy in particular which is presented in the next chapter.

Perspectives on Health

To a very large extent, culture determines how we understand health as well as what we perceive as the causes of ill-health (Lien 1992; Feldmann, Bensing et al. 2007; Fenta, Hyman et al. 2007; Helman 2007; Kline and Huff 2007). In Western cultures dominated by the medical model, the focus remains on individual intrapsychic experience or individual pathology and the relationship of disease with singular causal agents (Kiesler 1999; Tribe 2005), whereas research with refugees from different cultures has demonstrated that different cultures view these issues in very distinct and different ways (Papadopoulos, Lay et al. 2003; Feldmann, Bensing et al. 2007). In this study, the interviews across several different cultures brought out several themes to how the interviewees perceived health.

Health as Happiness: Many of the participants of refugee background stated that happiness and health were either synonymous or very closely related to each other. Some of the participants asserted that health and happiness are the same thing and not distinct from each other. Others spoke of internal happiness leading to good

health. As Hasina said, 'A person who is healthy has to be happy inside. If we are unhappy we are sick'. Dah Gay also ascribed her issues with back pain and heart palpitations to feelings of unhappiness.

A few spoke of the reverse, saying that if they were healthy they would be happy. This point of view was explained by Mu Dah saying:

If you are well then you will be happy, and you will have energy to live. When you are not well, you don't feel like doing things. You are not happy so you don't want to see people, you want to live alone. All those things, you can't... it means like you are not...that's not healthy. If you have all those then you will be happy and healthy.

Twelve of the interviewees remarked on the relationship between health and happiness, including interviewees from Karen backgrounds, Sudanese backgrounds and one of Afghan background.

Distinction between body and mind: Thirteen of the refugee interviewees maintained that there was a connection between body and mind, and only varied on their conceptualization of the closeness of this linkage. Some of them pointed out that the relationship between body and mind was loose or episodic using phrases like 'sort of related', and 'sometimes they go together' while others maintained that there was a very close connection. Among the seven interviewees who asserted that the body and mind were very closely connected there were two distinct ways of viewing the connection. The first was, as Zainab said, 'they [body and mind] are two separate things but very closely related'. The other perspective was, as Musu put it, 'I think it's the same thing, no different and everything that in your body is coming from here, mentally'. Two of the refugee interviewees were very clear that there was no connection between their bodies and their minds in terms of health and illness. As Kesi put it, 'I don't think the body illness and the feelings inside are related'.

While there were differing views on the nature and intensity of the body-mind relationship, almost all of the refugee interviewees connected internal feelings to external body symptoms at several points in the interviews, either while discussing their own health status or while discussing issues such as the causes of ill-health or complementary therapies or yoga as therapy. They often referred to internal states of

‘thinking’, ‘happiness and sadness’, and ‘worrying’ and related those to physical issues like pain, palpitations and breathlessness. Even Htoo Say, who clearly stated that issues of the body and the mind were not connected, later went on to say that the practice of yoga helped her to ease her breathing by removing bad feelings from inside.

This discussion on the connection between the body and the mind has considerable relevance in the context of the medical structures in place to deal with the health issues of refugees in Australia. As delineated in an earlier chapter, there is a clear distinction in Australia between the organizations that deal with the physical health of refugees and those that deal with mental health (DIAC 2008; QH 2008). This process was explained by Alexis who works within a refugee health service which mainly deals with the physical health issues of refugees. According to her, they only work with mental health issues if the clients present with acute symptoms. In all other cases, refugees are referred either to the trauma service or to a psychiatrist or psychologist. She explained that doctors in their clinic were very aware of what she called somatization issues but needed to rule out physical causes first. She agreed that this artificial demarcation between those looking after physical health issues and mental health issues was not an ideal situation, but stated that an integrated approach is a ‘Utopian’ one at this point in time. This viewpoint was shared by three of the four medical practitioners and suggests an area of conflict with the viewpoints of the majority of the refugee interviewees.

Faith in God as therapeutic: Several of the interviewees maintained that prayer and belief in God was the source of good health. As Mahtab said:

Body has to be healthy and mind has to be healthy. If you pray regularly you can have both, and also the spiritual side is very important. The All-Powerful will help us

Four of the Karen participants mentioned that they use prayer as towards their own good health. Several of them also mentioned the importance of forgiveness of the wrongs committed against them as being part of their own healing process. Shalini mentioned that she regularly used chanting of God’s name as part of her prayer and meditation, using prayer beads to count the repetitions. Naw Wah also spoke of using prayer beads as a form of meditation. All of the participants who spoke of prayer and

belief in God a source of health were also open too and utilizing different therapies for their health needs, which emphasizes their adoption of a plurality approach to health.

Environment as a source of ill-health: Five of the participants mentioned that people could be made sick by different environmental factors. Some of the factors mentioned included food, the place where one lives as well as the water source. Cleanliness and lack of dirt were also specified by some as a source of good health.

Besides these factors of the physical environment, the social environment was raised by many of the participants as a source of good health. As Zainab stated:

Sometimes if you have friends they will come and encourage you and support you and talk to you. Then you will feel happy and you will be healthy. But if you don't have that support and you get distress and then you think a lot and then...that can become...you will get sick.

A number of the issues relating to the social environment have already been presented in the section on loneliness and alienation as one of the settlement issues. Many of the participants spoke of this loss of social networks as leading to ill-health and that they really looked forward to the occasions that they could get together. Some of the occasions mentioned included festivals as well as English classes as well as other classes, such as those for learning crafts, run by different agencies.

The connection that many of the refugee participants made to the larger physical and social environment is congruent with the extensive literature emerging around the biopsychosocial nature of health and illness (Leigh 1997; Wise 1997; Pilgrim 2002).

Prior Experience of Health Systems:

Biomedicine and Indigenous Medicine: All the refugee interviewees had used the biomedical system in the form of doctors and medicines in their home countries. For those interviewees who lived in cities, such as Musu, Neda, Ler Say and Naw Wah, the medical doctors and the hospitals were the primary supports for dealing with their health issues. All of them generally went to private medical practitioners for minor ailments or to hospitals for major issues. However, access to these hospitals was not necessarily open to everybody and Musu spoke of having family connections in Liberia that enabled her to go to the best possible medical facilities run by Western

medical staff while Neda spoke of good hospitals in Afghanistan as being the province of rich and powerful people. For those who lived in rural areas, as most of the other interviewees did, health needs were met by a mix of medical doctors, village healers and local healing knowledge.

Especially among the Karen interviewees, minor ailments were largely dealt with within the family by using a combination of herbal medicines and massage. More acute ailments often took the specialized skills of healers called *Bane Daw Thara* and only if they did not succeed were the medical doctors approached. Similarly, Hasina spoke of the importance of the *Faqirs* in Sudan who were able to identify and cure ailments and she reported going to the doctors only when they failed. Shalini, on the other hand, lived in a rural town in Sri Lanka, but used biomedicine as her primary recourse for health needs. She supplemented this with Homeopathy for chronic problems like skin problems and allergies and used a range of home herbal remedies. Mahtab also had always relied on medical doctors in Iran for her health needs. She referred to her faith, saying that people of her faith believed in medicine to be healthy.

Home Remedies: All the refugee interviewees spoke of a range of powerful home remedies that they used for treating a number of health issues. They had learnt these remedies from their parents and from the elders. Some specific remedies mentioned included the use of fire ash or pomegranate peelings to cure stomach ache, tamarind juice for constipation, guava leaves for diarrhea, turmeric for allergies and itchy skin, alum to clean and heal wounds, neem and mustard tree twigs to clean teeth as well as heal stomach problems, and cloves and/or ginger to cure coughs. A number of other herbs were also mentioned in the interviews as having healing properties, and some of the interviewees considered that they had the expertise in their use. Unfortunately they could not find these herbs in Australia or else they said would have used them.

Other CAM Practices: Besides herbal medicines, different CAM practices were mentioned by almost all of the interviewees. Almost all the Karen interviewees also spoke of using a traditional practice of massage that involved children walking on their parents' backs and legs. This was again a skill that was passed down from generation to generation, and was still practiced by a few of the interviewees in Australia. Mahtab also mentioned CAM methods like cupping, a process of using

cups to create localized suction areas on the body as a healing modality, being practiced by others in Iran. However, she personally had not made use of these methods. Zainab also spoke of cupping and had used it as a way of dealing with ill-health and pain. Neda spoke of Unani medicine as a very popular alternative medical system in Afghanistan, Pakistan and India. She remarked that Unani doctors were very good but that they were more popular in the villages, while medical doctors were more popular in the cities.

Medical Plurality: The common thread that emerged through the majority of the refugee interviews was that they were used to a plurality approach towards dealing with their health needs. They spoke of treating themselves with home remedies and CAM practices like massage, followed by recourse to different types of healers depending on the convenience of access or the nature of the illness. They went to the Western doctor for acute physical ailments while other healers were approached for chronic illnesses or those which did not seem directly related to physical reasons. This plurality approach was also spoken of by one of the complementary therapist interviewees when she spoke on her work with refugees as being particularly exciting because:

... they were people who related so strongly to the notion of western herbal medicine. Even though they were not Western clients they understood herbs, and many of the herbs that we used were herbs that clients had used themselves. But more than that, it was their sense of relating to taking herbal medicine as a therapy, as well as their familiarity; many having a familiarity with massage therapies. So there was a natural sort of common language... with refugee clients they were already there because their mothers used them, their grandmothers used them. They came from cultures where it was so much part of their everyday life experience that it was - for me that contrast was so rich. (Erin)

Experience of Biomedicine in Australia.

Newly-arrived refugees in Australia have to go through an early screening, assessment and treatment program through refugee-specific services such as refugee clinics and torture and trauma services in most metropolitan areas (Woodland, Burgner et al. 2010) and community general practitioners and mental health

professionals in other areas (McDonald, Gifford et al. 2008). The refugee participants in this study had all gone through their health screening at refugee-specific services in their cities of residence. All of them had then moved on to community general practitioners for their physical health needs. The themes that emerged around their experiences with the medical system are explored here.

Views on medical practitioners: Many of the interviewees reported that the doctors in Australia were very good and had resolved many of their issues. As mentioned in earlier, one of these was Mu Dah who had experienced a great sense of relief when the lump on her neck was diagnosed as benign in Australia after she carried the worry of cancer for many years. Similarly, Mahtab reported that she had several dental problems that were resolved in Australia. Ler Paw stated that the doctors in Australia had saved her life by identifying the hole in her heart that was overlooked in Thailand. Even where the doctors could not help them, many of them asserted that the doctors had the right attitude towards them. Dah Gay explained that it helped her to just see the doctor even though he/she couldn't find the source of her problems. Just the fact that they were trying so hard to help her made her feel better.

Another point of view expressed by several of the refugee interviewees was that doctors were very effective for matters relating to the physical body but that mental health problems were not so well managed through the medical system. As Naw Wah said:

The doctors are very good in the physical checkup, like taking blood test, x-ray, urine and poo test, but they are more scientific side. But for the mental side, the thinking, they are not very good with that. May be they can't see it and they can't seem to point out what was wrong with me.

Chronic nature of problems: All of the participants spoke of going to doctors repeatedly and for a long time for the treatment of the chronic problems that they had identified (as presented in the previous chapter). They spoke of undergoing numerous tests including X-rays, urine and blood tests, and ECG tests without being able to determine the precise cause of the problem. However many of them appreciated the efforts the doctors were making to identify their problems. Further, they spoke of the confusion of being told to go to a counselor when they considered

that they had a physical problem and vice versa going to a doctor when they had troubled minds. As Neda questioned:

When my arms aching what counselor going to do? I go to doctor for medicine and he send me to counselor who just making me talk.

Another concern raised in this regard was the short nature of appointments with general practitioners. Hasina spoke of the usual appointments where the doctor didn't have the time to understand the problem and just gave some medicines or referred you to a specialist. She preferred the mental health services provided through the trauma services because they took their time in helping her. This matter was raised by several of the refugee interviewees who argued that doctors were generally well intentioned but did not have enough time for them. They particularly spoke of this when relating it to the trust they had for their complementary therapists. Ler Say, a service provider, also reported that several of the GPs that she took her clients to did not seem to provide adequate time or sufficient attention to deal with the complex needs of her clients. She asserted that refugee clients were not being listened to properly.

Many of the interviewees found relief with medication for some of their problems such as pain and breathlessness. While they were happy with the relief that medicines gave them, several of them complained of the lengthy amount of time that they had to take the medicines. Hasina went back to her doctor to stop her 'pain' medication after one year, but found the pain coming back the moment she stopped. Ler Paw also spoke of this matter in the focus group as:

I think taking the medicine too long may cause problem. I have been taking medication for a long time, almost a year and I still live on medicine.

Another problem raised by two of the other refugee participants was of the medicines causing problems in themselves in terms of side effects. Ava, one of the yoga therapists who had worked with refugees for several years in different capacities spoke of this problem as:

It's not part of their understanding that management of chronic disease from a western perspective is that you get put on a medication and you take it long term. So people stop and start their medications because they just don't kind

of view their health in that way that we separate out an acute and chronic. So a lot of people for example, stay on antidepressants and take it for a couple of weeks and then say "Oh, I've stopped taking that" or they say to me "Oh, I take it on the nights when I'm not sleeping so well". And I say "It's not a sleeping tablet and it doesn't work like that".

This concern was also raised by Neva, a complementary therapist, who found that many of her patients were coming to her after seeing multiple GPs and specialists. She reported that she would typically see people who were overprescribed and having serious problems of drug interactions that were not being picked up because of language and cultural issues. She argued that the system was failing refugees in this regard.

Interpreters: All the interviewees maintained that the use of interpreters by doctors was critical to their health needs. They reported that general practitioners who were used to refugee clients tended to be very good about organizing appropriate interpreters, either face to face or through the telephone interpreting service. However, a number of matters were raised about the use of interpreters.

In many cases, the availability of appropriate interpreters was a challenge. Many of the refugee participants reported that they went to general practitioners based on whether they used interpreters or not. Word-of-mouth was important to them in terms of picking a doctor and they tended to go to one either recommended by a service provider or by other refugees. However, not all of them had the choice and several of them reported going to a doctor even if he/she did not use an interpreter. Several interviewees also reported using their school-going children as interpreters during consultations.

All the service providers and the complementary therapists reported that more than a few general practitioners and some hospitals were either not using interpreters or using children as interpreters. While not endemic, this was reported as a problem in metropolitan areas that was even more acute in regional areas. Some of them reported incidents where such inappropriate communication had led to misdiagnosis as in the case of a mother not reporting missed periods because her child was interpreting, and, in another case, a hospital patient who could not communicate without an interpreter and continued to be treated for PTSD when she was suffering

from cancer. Alexis, from the point of view of a centralized refugee health service, reported that they used the settlement agencies in each area to monitor such concerns and then followed up with the respective practitioner or hospital for providing appropriate training or information. While service providers continue to provide education to general practitioners and hospitals on cultural competence and the use of interpreters, several service providers pointed to the lack of funds towards providing this service more effectively.

Even in locations where interpreters are provided, the difficulty of organizing one raises access issues. Several of the refugee participants reported that they had to wait days or weeks to go to the doctor, even when they were sick, because an interpreter needed to be booked in and it could take up to a couple of weeks to arrange one. As Kesi said, 'When we are sick, it will be really good to be able to see the doctor straight away'. Dah Ey reported that she did not go back to report ineffective medication for her neck pain as the interpreter was at the clinic only on Thursdays and she had English classes on Thursdays. This matter was also raised by several of the service providers as creating health problems for refugee clients. Esther spoke of this as the gaps in the system through which refugee clients were slipping. She said that it created a situation for clients where the extended wait for an appointment often could lead to worsening of the illness that they were suffering from.

The lack of any processes to support interpreters was raised by one of the complementary therapists, Neva, who suggested that the wellbeing of the interpreters is often overlooked. She argued that there was no process of debriefing or any other support for them, even though many of them were vulnerable to trauma themselves. She reported that she had seen symptoms displayed by interpreters during the sessions with refugee clients and suggested that complementary therapies would be useful in terms of providing some support to them.

Counseling: There were two distinct points of view about counseling as an appropriate response to mental health concerns. Of the thirteen participants who had been to see counselors, eight were very positive about the counseling as being of help to them. Most of the Karen participants viewed counseling as helpful, which raises the impact of culture as a factor in terms of views on whether talking about painful events is experienced as valuable and therapeutic. They spoke of feelings of

encouragement, acceptance and happiness as effects of counseling. Several of them reported that culturally and socially they would not speak out about many of the traumatic events in their lives, and that these could 'explode inside'. They pointed out that counseling had helped them to release these feelings. Naw Wah even ascribed her ability to eat properly and to put on some much-needed weight to the help she got from counseling. Similarly, Shalini also stated that she had been able to reduce her stress levels by going to a psychologist and talking her problems through. All of these eight participants maintained that counseling was extremely important towards dealing with their mental health issues.

There were also some very strong opinions expressed against counseling as a therapeutic intervention. Several of these were from participants from African nations who asserted that rehashing their lives to a stranger was of no use to them and that they benefitted more from the craft classes and yoga classes they attended. Neda from Afghanistan also spoke on this at some length saying:

They making you talking too much and talking about what you doing in Afghanistan, what you do before and, you tell and after you remind again, and you cry and upset. Should be make it doctor organize different program, like stress people, depression people go take it on the picnic, take it in the park, with some group together and make it happy, those people. Maybe music, music program, singing program, dancing program This program much better for people. I think like this. I don't know about other people. And some sick people need help to be happy. Relaxing program help and yoga program, and these things maybe help. You go every time, you see psychologist and this doctor talk to you and make you too happy? No, upset you. More upset and more cry you. It's not help. It does not, these things.

This point of view was also reflected by one of the general practitioners, Behnaam, who argued that employment opportunities as well as therapeutic applications of craft, exercise and music would be better than counseling for many of his clients as he believed that they could then 'look to the future and see where they are going, not where they have been or what they have gone through'. This approach has also been reported in the literature relating to distinct cultural groups such as Vietnamese refugees (Kidson 1993) and elucidated as 'talking about painful events may not be

experienced as valuable or therapeutic by refugees from societies in which psychological models are not hegemonic' (NCTSN 2005:32). While this is an important consideration, it is not a blanket rule as the Karen people come from an environment where Western psychological models are not the norm and yet almost all of them spoke of the benefits of counseling.

The cultural reactions to counseling were also explored by several of the service providers and complementary practitioners. Several of them reported that talk therapies were found to be very useful for refugees from the former Yugoslavia, who seemed to have an affinity and acceptance of the approach. Refugees coming from Middle Eastern countries as well as from African countries were reported as being less interested in counseling. Esther stated that the majority of her recent clients, who were mainly from the Middle East and Africa, were not as open to counseling as they related it to mental illness. Kira explained the evolution of the trauma services as one structured essentially around counseling as therapies, and reflected on the inadequacy of this with the changed demographics of the last decade where:

... people in the early 2000s come from African backgrounds and kind of go 'Whoa, no way. I don't want to talk about that', and 'I'll go and talk to my priest' or 'I go and talk to my family or my whole community if I'm having trouble about that. I'm not going to talk to a complete stranger, one on one, in this closed room setting'.

In terms of cultural views, Neda's antipathy to counseling was also reinforced by remarks by one of the complementary practitioners who had worked for many years within trauma service. Neva, as a complementary therapist, stated that many of her Afghani clients, especially the men, could not relate to the concept of counseling and that 'counseling was another torture for them'. She affirmed that it was not a blanket approach for everyone. For those clients who did comprehend the concept of counseling and were getting something out of it, that modality was fine in itself, or could be used in tandem with a CAM that the client was comfortable with. For those that culturally had issues with counseling, forcing them to go through it only created more barriers.

Several of the service providers and the complementary practitioners spoke of the changing role of counseling as it responded to the different cultures that are settling

in Australia through the Humanitarian program. The changing role of counselors included more psycho-educational and promotional approaches, according to Kira, a service provider, who also pointed out that counselors had begun to adopt more holistic approaches, adapting their approaches to the needs of the individual client and community. This flexibility was also spoken of by Rez, who is a counselor herself and had set up an exercise program for men that included a module on yoga. According to her

...as a counselor what we started to see is that while counseling is useful for a lot of our clients, with counseling alone we are not able to address a lot of the issues of our clients. Some of the issues are loneliness and isolation, not work, being at home. So we started the exercise program so that the clients could leave the house, mix with others of different cultures and also the benefits that exercise gives. So we started the exercise program as complementary to counseling.

Erin, who worked for several years within a trauma service, said that counselors are increasingly taking on advocacy roles for their clients and helping their clients to enter and settle in the community. The counselor advocate role, in turn, helped to develop a trusting relationship between the client and the counselor making it more likely for the client to then speak about some of the emotionally distressing and traumatic events from their past. She suggested that this trust was extremely important in many non-Western cultures where one did not speak about personal matters to anybody until one had trust in them. A family and community development approach adopted by counselors was also discussed in the focus group of service providers, where the consensus was that this kind of approach was much more effective than the traditional one-to-one counseling approach.

Views on Complementary Therapies

Background of CAM approaches:

The principles of CAM approaches were not one of the areas that were explored during the interviews. However, this was spoken about at some length by the complementary practitioners. Neva is a Homeopathic practitioner who has treated many health concerns of refugee clients over several years. She stated that the key aspect of her approach is Holism as compared to the reductionist approach of

biomedicine. She suggested that when people have been traumatized they are already in a state of dissociation and cannot integrate or feel different parts of their body. She argued that the health system reinforces this separation rather than integrating them as one being, a whole person, a view widely supported in the literature (Jonas and Levin 1999; Guinn 2001; Shuval 2006). As she explained, her approach was always the widest possible as

I will look at their entire lifestyle. So we look at what are they eating, what are they drinking, what kind of other habits they have. So I kind of expect people to work with me with those sorts of things. So they could be eating and drinking things which are completely counterproductive to their symptoms, it's actually enhancing their anxiety. So we look at what sort of foods could we be eating that's going to nourish my nervous system rather than rip it to shreds even further. So people become a much more active participant and it's not hard. It's not trying to get people all to do these, you know, really out there things. It's just little changes, small things.

She pointed out that Western medicine was very good at dealing with symptoms quickly, but not so good at dealing with root causes. It was excellent with acute problems, such as those who requiring surgery or someone having a psychotic episode. She went on to talk about the context of the service she had worked with, stating that ninety five per cent of their clients were survivors without acute symptoms. They just had all these chronic symptoms that put them on, as she put it, the 'Western merry-go-round' that seemed to go on forever. CAM therapies worked very effectively with these kinds of issues.

She also argued that CAM approaches are cost effective for two reasons. Firstly, they allow people to be self-empowered and to self-manage, allowing them to develop skills for living. As such they can avoid being stuck in the health system in the long term and accordingly reduce the costs. Secondly, she stated that the CAM approaches use medicines and practices that are very cheap, giving the examples of acupuncture needles, homeopathic remedies and vitamins and minerals. She also mentioned therapies like massage and yoga that have little more than the time of the therapist as a cost of therapy.

Ava, a yoga therapist, also spoke about the importance of CAM approaches in working with people with chronic problems. She maintained that many of the health concerns that refugees face are those that caused within and by the mind-body connection. She argued that CAM approaches are ideally placed to work with this connection, dealing with the matters of the body and healing the mind at the same time. She used the same statistics and metaphors as Neva, suggesting that 95 per cent of the people that came to their service were out of survival mode and could be healed by CAM approaches, while five per cent were still in survival mode and needed to be healed through biomedicine. She argued that CAM approaches were very effective for working with refugees because

I feel that complementary therapy brings the normal back. It doesn't medicalise absolutely every part of people and compartmentalize it. It integrates the whole and that's where yoga and tai chi or just quiet sitting is an extra step for those who are ready, because they can start to get in touch with actually being very powerful people.

Experience of different CAM remedies in Australia.

All of the refugee interviewees had used CAM therapies in Australia. Most of them had accessed these therapies through trauma services, except for Shalini who had gone to a private Homeopathic practitioner. Some of the therapies they mentioned included Naturopathy, Flower essences, Massage therapy and Homeopathy, while Acupuncture was also mentioned as a useful therapy by two medical practitioners and one complementary practitioner.

All of the Karen participants had used herbal remedies and floral essences prescribed for them by a naturopath working within the trauma services. They generally reported that the herbal medicines were most useful in terms of helping them to sleep better. They also confirmed that the remedies had some effect on pains and aches, though Mu Dah related that to the improvement of sleep patterns leading to more rest and accordingly more happiness and less pain.

Shalini had been regularly using Homeopathy to work with her skin allergies and breathing difficulties. She reported that the Homeopathic treatment had taken a long time but had helped her a lot with the skin allergies, while she believed that her breath issues were better addressed through yoga. While Homeopathy is one of the

CAM therapies offered by some trauma services, Shalini was the only refugee participant in this study that had used this healing modality.

Most of the refugee respondents had experienced massage as a form of therapy. Two of them reported an aversion to being massaged as being too ‘ticklish’, while all the other participants reported a sense of relaxation, and easing of chronic pain issues. Erin, as a complementary therapist, reported that many of her clients from the former Yugoslavia responded very well to massage even when they presented with extreme somatic issues. Many of refugee respondents also reported massage therapy as very akin to similar healing processes in their own cultures.

None of the refugee participants had experienced acupuncture as a therapeutic approach. This CAM was however spoken of by one of the medical practitioners, Behnaam, who referred his patients to acupuncture for weight loss and for stopping smoking. Neva, as a complementary practitioner, also spoke of acupuncture as having been widely used within their refugee health program and argued that clients had reported fantastic results with it. She also engaged with the issue of the torture and trauma literature that suggests that the needles used in acupuncture may trigger flashbacks in survivors of torture. She argued that this was really only applicable to people who had actually been tortured, and that many of their clients suffered from trauma without actually being tortured with needles or sharp instruments. As such, acupuncture worked quite effectively for them.

Funding of CAM programs:

The dominance of the biomedical paradigm has ensured that CAM therapies have had a precarious existence in terms of the funds available for running the programs (Gaydos 2001; Peters, Chaitow et al. 2002; QPASTT 2006). Both Neva and Erin, complementary practitioners, spoke of the difficulty that they had always faced in terms of funds. Neva reported that her organization was unable to obtain government or charitable funding for the natural therapies program during the nine years that she was there. Instead they had to manage with some sponsorship from natural therapy companies in the form of free or subsidized medicines as well as the volunteer hours put in by different CAM therapists. This particular program was finally closed in 2010 as reported by Rez, who reported that the program was very helpful to her clients and was only closed due to funding difficulties.

While speaking of another organization with a similar natural therapies program, Erin reported that the funding was initially very ad-hoc and not appropriated directly to that program. However, over the years, the programs have become more mainstream, with funding directly allocated to natural therapies that work specifically with on-arrival programs. Alexis, who works at a refugee health clinic, also raised the issue of funding. She asserted that lack of funding combined with the lack of availability of bulk billing was the reason why they could not refer clients for CAM therapies even though she believed they would benefit through availing of these therapies.

Volunteer/casual therapists in natural therapies: Because of the paucity of funds, CAM programs that support the health of refugees are often dependent on the free hours donated by therapists. This was raised as a major problem by both service providers and therapists. This was one of the issues raised during the service provider focus group and the consensus was that volunteers, while well intentioned, do not ensure the best possible outcomes for the clients. As Neva phrased it:

You wouldn't have a whole bunch of volunteer counselors running around, so why would you want to have a whole bunch of volunteer natural therapists, it is work with the same vulnerable people.

Erin also extended this issue to include casual workers as against regular employees, where she considered that there is a difference in quality of service between contracting people to work on a sessional basis as against truly integrating them into an existing health service.

Medical Pluralism and Integrative Medicine:

As discussed in Chapter 3, there is an increasing body of literature suggesting that an approach integrating biomedicine with different complementary and alternative therapies would better address the complex issues of the health of refugees than the present dependence on biomedicine (Aroche and Coello 2002; Peters, Chaitow et al. 2002; Papadopoulos, Lay et al. 2003; NCTSN 2005). This approach would focus on all aspects of wellbeing including the physical, the psychological, the social and the spiritual and provide a range of effective and safe healing modalities that stress prevention, self-care and self-empowerment and establishing healing partnerships

(Libster 2001; WHCCAMP 2002; AIMA 2009). Some of the themes that emerged in this study regarding the integration of modalities are delineated here.

Openness to Plurality: As stated in an earlier section, many of the refugee interviewees had a very positive attitude towards the utilization of a number of different healing modalities, and almost all of them said that they benefited from using more than one modality at the same time. As Mu Dah spoke about her experience:

Doctors are helping me with the medicines. They helping me with the counseling and encourage me. And with the massage and all those, they've been helping me a lot so I'm much better now. And now only whenever I'm tired only, I don't think about anything now...when I'm tired, I still get that heart beating. Even when here [Interview location], they invite people for meeting with the women group or go to job network for appointment...even things like that make me really nervous and I started shaking and heart pounding. I get really scared and I feel like going to the toilet but I can't go either but since with [name of yoga teacher] help with the yoga class and with other people's help, now I'm much better. I don't have anything now.

This openness to the different modalities was spoken of by many of the refugee participants. Shalini asserted that there was no difference between the biomedical and the homeopathic practitioners that she went too and referred to both of them as 'Doctors'. She pointed out that each had their strengths and she went to them depending on her needs.

Most of the other interviewees were also open to the use of CAM therapies. Three of the service provider interviewees spoke of the fact that they used CAM therapies themselves and that they did not see why refugee clients should not get the same benefits as they did. Alexis spoke of this at length saying:

I go to a chiropractor, take Ayurvedic medicine, practice yoga, and also take medication. I believe that there is a close body-mind spirit connection and there are physical manifestations of many mental issues, and so we need many different modalities for dealing with them, particularly for people from different cultures. There is a lot that the West does not understand about

spirit and how it affects mental health and health, and it has a lot to learn from other cultures. I think that is how it needs to work with refugee communities in particular.

Esther had a unique perspective on this issue as she was a practicing biomedical doctor in her home country. Further, while she was a very experienced settlement worker, she was also a trained naturopath. She believed very strongly that biomedicine and CAMs were two sides of the same coin and that CAMS were more useful for preventing problems or for dealing with chronic problems as well as mental health issues that biomedicine was not as effective in dealing with. This openness was also mentioned by Behnaam, one of the general practitioners, who argued that biomedicine and CAMs have their own place and roles, and that it is important to utilize treatments based on their strengths without getting too excited about it. He gave the example of one of his patients who wanted to avail of a chiropractor's help instead of getting her child vaccinated as one where this multimodality approach can go wrong. He asserted that, just like the different specialties work together in his clinic, the different healing modalities could work together. As he said, 'Each has their area of expertise and they can work together'.

Two of the other medical practitioners, Olivia and Robert, were very positive towards modalities working together. Olivia was already combining yoga with her psychiatric practice while Robert was offering acupuncture as one of the services in his practice. Claire, who worked at a refugee clinic, was open to the possibility but did not speak much on the issue. Phillip was completely against the idea, as he believed that the lack of evidence that he saw in the other modalities made them very suspect. He strongly asserted that mental health issues were best dealt with by the specialists and not, as he put it, by 'quacks'. He also spoke of a patient who stopped medication on the advice of a naturopath, and subsequently had a serious problem because of that. He maintained that he was only prepared to work together with any other modality if enough scientific evidence was available.

Integration of the Modalities: While the interviews revealed widespread approval of CAM and Biomedical therapies working together in an integrated way, there was also some disbelief towards the practicality of an integrative model of refugee health in the present environment of a dominant biomedical paradigm. Of those who had

stated the benefits of CAM approaches, Alexis (refugee clinic), Robert (general practitioner) and Lyla (yoga therapist), all used the word ‘Utopian’ at the suggestion of an integrated model. As Alexis explained, at this time all the present systems are geared towards biomedicine and, in the case of her organization, getting people physically well. All their targets and funding were focused towards the achievement of these goals through medicalised approaches and they had neither time nor resources to working in an integrated approach. She reflected on the separation of the body and the mind in the present health system and suggested that the only way that integrative medicine would work is if ‘the different organizations involved in refugee health, mental health and settlement services worked together really closely or ran programs together’. As a service provider, Esther also reflected that presently the system does not support the CAM approaches and suggested that the different practitioners needed to work hand in hand and complement each other rather than work against each other.

While complementary approaches were being used concurrently in some trauma services, not all of them were completely integrated models. As Rez pointed out, they had a natural therapies program in their service. As counselors, they would refer their clients to this program if they considered that the client would benefit from it. She said that for issues of body and back pain, anxiety issues and grief and loss issues, the counselors would work together with the natural therapies. Through this process many of the issues that one modality did not address were dealt with by both modalities working together. However, this approach did not necessarily imply very close association between the counselors and the CAM practitioners. In the context of this same service, Neva argued that, rather than the present separated sections, she would prefer a range of complementary therapists working together with biomedical practitioners and counselors to do an assessment and work out a path to health with the client.

Erin was the only interviewee to have worked within a service that had an integrated approach to health, with counseling, naturopathy and biomedicine all working together and her views are presented here in some detail. She stated that teamwork and a case discussion model was a critical component to this particular integrative model where the different practitioners and the client sat together to map out the direction the client wanted to go in. She stressed that the client’s voice was critically

important in the process and the client needs to choose the mix of approaches most appropriate to them and work with different practitioners accordingly. She affirmed that communication between the practitioners and also with the client was very important to the success of the process.

Erin also reflected on the benefits to complementary practitioners in working so closely with biomedical practitioners, suggesting that, from a professional point of view, it was very relieving to know that a client has had a full medical work-over and they were no untoward pathologies lurking. She also considered that clients were more at ease with the team approach as they were generally familiar with biomedicine and may not be very familiar with all the CAM approaches. She spoke of the sense of self-esteem she experienced working as an important component within an integrative model of health, and of valuing the work within a context where complementary practitioners were not in conflict with the medical establishment and client attitudes were not conflicted about which approach to take. She argued the case for an integrated approach to health as:

My basic kind of premise is that the health concerns that refugees present with are enormously complex, and can't really be stereotyped other than they are complex. And the interrelationship between the mind, body, spirit, emotions, sort of really comes to the fore around refugee issues. And as such, a comprehensive multidisciplinary approach, you know, is really needed. It's really well established now, that, you know, that there needs to be many threads towards providing good health care. And I think underpinning that is really the importance of those models being integrative, rather than separate. So that the different health care practitioners can work together rather than in isolation... there needs to be an allowance for cultural difference and an allowance for different ways of understanding the body, different ways of understanding symptoms, that not all physical and psychological presentations can be - can neatly fit into biomedical constructs is really paramount. That people express their distress in a whole range of different ways. So rather than privileging one way over the other it's important to allow, in a sense, choice for clients around the way that they would like their health care to be addressed and attended to.

The concepts of medical plurality and integrative medicine were supported by nearly all the interviewees, both refugee and others, but there were differing views, as mentioned earlier, as to the possibility of adopting these concepts in the present biomedicine dominated environment.

Summary

This chapter explored the experiences of refugees in addressing their health needs via biomedical models. The key issues that emerged included divergent views on health and health as happiness, dualistic approaches to body and mind, role of faith in healing, environment as a source of ill health. A number of barriers to accessing biomedical systems were identified including focus on physical issues, not being listened to, inability of biomedicine to deal with chronic issues, and problems with accessing interpreters. All refugee participants had utilized diverse forms of healing systems and that medical plurality was important to them. Participants identified strengths of alternative practices in addressing chronic health issues but pointed to the some of the issues with the present system including costs and power dimensions. Yoga therapy is a CAM approach and is clearly placed as an alternative practice in terms of supporting health issues. The issues and experiences of CAM approaches discussed in this chapter clearly had relevance to the utilization of yoga therapy both by itself and as part of an integrative practice. The next chapter provides the themes that emerged from the interviews and the focus groups relating to the benefits or lack of benefits of the yoga practices as experienced by the refugee participants and analyses as to whether their health needs were met through the practice of yoga.

Chapter 7: Themes - The Yoga Experience

Yoga is a holistic method that works towards integrating the body, mind and the consciousness and it also offers many practices that help to prevent or alleviate pain and suffering at many levels (Kepner, Strohmeier et al. 2002; Penman, Cohen et al. 2008). As discussed earlier in Chapters 3 and 4, it can work effectively as a CAM approach, either by itself or in combination with other CAM approaches and/or with biomedicine, to enable individuals to empower themselves and to progress towards greater health and freedom from disease (Mohan 2006; McCall 2007; PMTF 2010).

In this chapter I present the themes that emerged from the interviews and the focus groups relating to the benefits or lack of benefits of the practices, as experienced by the refugee participants and whether their health needs were met through the practice of yoga. Then, I examine the themes around the relevance of yoga as a CAM modality and as part of Integrative Medicine, as perceived by the interviewees. This is followed by a discussion of the process of formation, the composition of the classes, as well as the perceptions of the participants as related to yoga. I further look at the details of the practices that impacted on the participants, such as the class content, methods of practice, communication methods, use of specialized techniques, regularity of home practice, frequency of classes, availability of child support, and stages of settlement. This is then followed by a closing discussion on some aspects of yoga research that were raised by the participants.

Benefits/Lack of benefits of Yoga Practice

All the refugee participants spoke of a number of benefits that they had experienced as a result of their participation in the yoga classes. Most of them pointed to the benefits as being long-lasting and, in many cases, helping them even after a month after the end of the classes. Most of them experienced the benefits as multi-layered with the postures, the breathing and the relaxation techniques each providing multiple benefits. Mu Dah summarized the range of benefits that she experienced from yoga as;

The yoga help with the pains on the neck, your body aches and pains and things that... by doing it... like the feeling or things from the inside, it helps to

relaxes you with that. Whenever I feel the heart beating fast, I do that [the breathing exercise – breathing in and out] and with the neck pain and whenever I feel that my body aches, I do that. In the morning when I get up, I do it also. I used to be quite skinny. And since I've been doing the yoga class ... I sleep really well. I used to didn't sleep very well and now because of the sleeping, now I put on a bit more weight. It helps with everything including the physical pains and the unhappiness and things like that inside.

The impact of yoga practice on health was best described by her when she said that that she felt better and better by practicing yoga. As she put it, 'practicing yoga, things will not go straight away but improving gradually'. The multiple benefits that were experienced through yoga were discussed extensively during the focus group of refugee participants and the consensus was that there were numerous positive effects, and these are incorporated in the individual findings that are presented a little later. Despite several questions into the possibility of some negative effects due to the practice, the members of the focus group insisted that there were no negative effects.

The multiple effects were also noted by Ler Say who had spoken to a number of the refugee participants who had attended the yoga classes. She said that many of them came from similar backgrounds of trauma and had very similar clusters of symptoms. She affirmed that many of them were having difficulty coping because of their health issues and that the yoga classes were really helping them in a number of areas including getting better sleep, having less pain and being able to breathe better. Ava, as the yoga therapist of the same group, spoke about one particular benefit that relates back to the earlier discussed correlation between health and happiness. As she pointed out:

When I did that evaluation of the group earlier in the year, the one question about "Is there anything you hope to gain? Is there anything else you gained from the group?" one woman said "It just makes me happy". So - and I mean, they all look happier afterwards.

While most of the other participants all spoke of long term benefits from yoga practice, two of the participants described the relief they got as very short term, in one case restricted to the time she was in the class. The other found that all her symptoms were reoccurring once she stopped practicing. Generally the range of

effects was in relation to the health issues as detailed in Chapter 2, and is presented as follows.

Relief from chronic pain. All thirteen of the refugee participants who had spoken of issues of chronic pain also said that they had relief from the symptoms of pain when they practiced yoga postures and breathing. Early morning pains were a common symptom that was spoken of, with many of the participants either getting whole body pain or pain in specific body parts like the neck, the lower back, the legs and/or the hands. All of them informed that when they did the postures and movements that they had learnt in class, they were able to alleviate the symptoms for most of the day. Some, like Dah Gay, pointed out that the pain they experienced before starting yoga classes was unbearable. Dah Gay said that she was earlier dependent on her children to do a step massage to relieve her pain but now she did the yoga practices on her own and felt much better in the process. Musu also said that she could not move her leg in the mornings because the knee was so stiff and painful and that consistent practice of yoga postures helped her move relatively pain-free. Lyla, from the point of view of a practitioner, spoke about the way in which yoga helps practitioners to deal with issues of pain as:

In yoga we say that the body carries the pain of the mind in the joints, ligaments and tissues. By opening out these blocks for the short period of the practice of postures, and then relaxing the whole body we are retraining the body and the mind. When we do this enough times, the practitioner is able to do this at will, say for example just before going to bed.

While the relief from pain is was a significant improvement in itself, some of the participants also pointed out that it had secondary impacts such as less insomnia and improved confidence on their lives. As Paw Say said, ‘I can sleep much better since my neck is not in pain’. Several of the participants also spoke of the combination of taking pain medication and doing yoga practices as a routine that they used to deal with their chronic pain issues. Both Neda and Naw Wah spoke of an early morning routine of medication and yoga as one that enabled them to get through the rest of the day effectively without pain.

Relief from breathing problems: The majority of the participants who had breathing difficulties, such as shallow breathing or breathlessness, said that practicing yoga had

given them relief. Zainab had said that when she worried she was not able to breathe properly and used to get a sense of tightness in her chest. She felt much better with the practice of the physical postures and as she said, ‘the pain from my chest was vanished and I can breathe’. Paw Say had serious breathing problems which had even caused her to be hospitalized in Darwin the day after landing in Australia. She stated that the *pranayama* breath practices were very helpful for her as:

It helps because when you do the breathing it seems like go through the whole body. The breathing part, when you breathe, the thinking goes away as well. I feel happier.

Several of the participants made the connection between breathing issues and ‘thinking too much’ or ‘worrying’ and confirmed that yoga helped them to deal with breathing difficulties by allowing them to relax and not think too much. Most of the participants who has issues with breath experienced them in combination with other issues of pain, insomnia, anxiety, and stress and affirmed that yoga was able to help them to get relief in multiple areas.

Relief from insomnia. This was also an area where many of the participants spoke of alleviation of the problem. The most common process recounted was relaxation of the muscles after the practice, accompanied by ease of breathing and lessened pain and then followed by being able to drop off to sleep relatively easily. Some of the participants also experienced fewer nightmares and woke up feeling more refreshed. Several of the participants pointed to a correlation between the regularity of their practice at home and the ability to sleep well on any particular day. As Hasina said:

I can feel the difference when I practice yoga I can sleep well. When I stop... similar to yesterday... I did not do it and at about 2 am I woke up and could not sleep anymore and was still awake until morning.

Many of the participants spoke about the intense feelings of relaxation they experienced in class especially during the practice of *Yoga Nidra*, which is a relaxation/visualization technique widely used by the Satyananda school of yoga. As both the Melbourne and the Brisbane group were run by therapists of that lineage, they had both used the technique in class with considerable effectiveness. Musu, in

particular, said that while she had sleeping issues normally at home, she would fall asleep as soon as the relaxation began and:

Sometime when we finish now, well everybody is finished, I am relaxed and I sleep - so I can be snoring and everybody - it's always happening to me, so everybody that know me say, '[Musu],[Musu], why are you sleeping'.

Neda also spoke of the association of attending class and feelings of relaxation and sleepiness. She said that she was sad that the classes had ended as it had helped her with her problem of getting adequate sleep.

Relief from stress, anxiety and panic. These were chronic issues reflected on by many of the participants. Almost all of them also spoke of alleviation of the problems using phrases like 'thinking less', 'thinking goes away', 'thoughts getting out of your mind', 'peace of mind', 'bad things going away', and 'not frightened any more'. Many of them stated that the physical movements helped them to relax and to stop being anxious. As Shalini described it:

When I am doing yoga I am not thinking or worrying. I have to concentrate on my breathing and the movement and my thoughts become less and less. I feel calm and much better by the end of class.

The lessening of anxiety due to the practice of concentration during in the yoga practices was one that was spoken off by several of the respondents. Mahtab said that when she did other forms of exercises she could still think and worry, which she could not do with yoga. She had to concentrate in yoga because there were so many things to do and her mind had not the time to worry. Musu also spoke about her body getting flexible and her mind being focused on the practices, thereby increasing her concentration and lessening her anxiety. As she said, yoga:

makes me feel - I hope that I'm doing it right and I'm concentrating and, it bring peace of mind to me. That my mind is focusing, I'm relaxing doing things. I don't have to - it's something that when I'm doing it I don't have to think about - worrying about things. What am I going to do? Or these things, blah blah blah happening. I just focusing on if I'm doing this, this is what's going to help me. To my health. That's what I focus on about how I can feel.

Several of the participants also pointed out that yoga practices were very helpful for dealing with panic attacks. The rapid heartbeat, shallow breathing and physical tremors that they described as the symptoms of their attacks were often experienced in public spaces and in anxiety-evoking situations like going to a job network. Several of the respondents particularly pointed to *pranayama* breathing techniques as very helpful when they started feeling intense anxiety or panic, saying that if they focused on the breathing correctly the symptoms would lessen to manageable levels. Mu Dah stated that she had used the breathing techniques several times when her heart ‘had started beating really fast’ and she was able to calm down quite soon. Musu also spoke of how the breathing techniques worked as, ‘when you're breathing you relax your mind, I don't know how to explain it, focusing your mind, everything, you know’.

Another practice that was mentioned by three of the respondents as being of help was the lion technique which involves a specific physical posture as well as a breathing technique similar to a lion's roar. While the other two spoke of the benefits of the posture when practiced in class, Ler Paw carried the practice into the public sphere in her own unique way as she described:

For me, I think a lot. Sometimes I walked down the road and forgot about things. Like the other day, I went with [friend's name] and we reached train station. All of a sudden I did the lion's roar out really loud. She was so shocked and said, 'what is wrong with you? What were you thinking about?' I told her that I did this so that things will go away from my head. yes. I screamed really loud. Every time thoughts come through my head and I think a lot, when I do that, it tends to go away.

While she was aware of the inadvisability of continuing the practice in such public spaces, she asserted she would maintain this practice whenever she could as it helped her so much with her issues of stress and anxiety. These issues were also spoken of by Ler Say who attended most of the yoga classes and maintained that they had been very useful to the participants in terms of dealing with their issues of stress. As she explained it:

When we do the relaxation time... they know it's a ten minutes relaxation so... they will relax straight away. For those who were new for the last

session, they open their eyes and try to relax but you can tell whether they relax or not... so it depends on the idea that they have and we... obviously we know that they all come from a pressure... a trauma background... and these kind of things don't go away quickly no matter what you did... it's your body response... so if they can have more lessons and get used to the idea of the practice every week, I think it would be the best way to get out of their stress which they didn't know what the stress was in the first place. Because that's what they complain about back pains, body aches and pains... these are kinds of stress but they didn't know that it is part of their mental thought as well.

Neda also reflected on the benefits of the yoga classes for refugees as she said that there were many with similar issues of stress, anxiety and depression. She said that they suffered from worrying about their families, their parents and others back in their home countries and that it had a lot of impact on their health. Because of its effectiveness in dealing with this stress, Neda said, 'Yoga class very important'. Mu Dah reiterated this saying, in the context of yoga classes that 'our health is getting better and the bad experience that we face also is gradually disappearing'.

Weight Management. Three of the participants said that they attended yoga classes to lose weight. This was one objective that none of them found that they had achieved. Htoo Say said that she was the same weight as at the beginning of the classes but that she was 'very light and not so heavy anymore'. Josephine said that her weight had not changed at all through the course of the classes but that she was more at ease with her body. Musu also had a similar experience with no loss of weight. However she spoke of improvement in her knee pain, which was the main reason why she wanted to lose weight.

The aspect of needing to gain weight was conveyed by only one participant. Naw Wah said that:

Now I am putting on a bit of weight. If you see me when I first arrived, I was really skinny, and even my eyes, there, that area, very black. I look like a ghost even at that time. I go to yoga classes. Now I am much better.

Musu also spoke at length about the issues of weight gain among African women. She pointed out that most of them were gaining a lot of weight after coming to

Australia because of the lack of exercise and the change of eating habits. She considered that this is leading to obesity and allied problems such as diabetes and high blood pressure. She suggested that yoga classes can be effective for weight loss if they included advice from a dietician about food and other aspects of self-care.

Reduction of medicine dependency. Four of the refugee participants said that they had reduced their intake of medication as a result of regular yoga practice. Naw Wah used to take Paracetamol ‘all the time’ for headaches, and had completely discontinued the medicines since she started yoga. Similarly Htoo Say took pain medication for her back and leg pains but found that yoga could ease the problem better. Shalini said that she had to resort to her ‘puffer’ [oral inhaler] much less for breathing issues after she started practicing yoga regularly. Hasina also spoke of discontinuing her sleep medication and using yoga practices to help her to sleep.

Empowerment. As noted in Chapter 2, in addition to the trauma of the refugee experience, many refugees settling into Australia lose their familial and social networks, face discrimination and hostility, and have difficulties in accomplishing the tasks of settlement such as learning English and getting a job (VDHS 2008; RCOA 2010). These complex problems can lead to issues of perceived loss of control of the world around them and loss of meaning, identity and status, and disempowerment (VFST 2007; VDHS 2008). Kira, one of the service providers, spoke about this issue as ‘what I’ve observed about when people become most vulnerable in the early stages of their settlement is very much about a loss of sense of self, and a loss of sense of purpose’. As presented in Chapter 4, yoga can provide the techniques and lifestyle that, once learned, enable the participants to practice at any point of time, and without dependence on any person or equipment (Young 2001). This enables them to develop a level of independence in terms of dealing with their health issues (Forbes, Akturk et al. 2008).

Several of the yoga therapists spoke about this issue of disempowerment and the place that yoga has in terms of dealing with this problem. Shakti argued that the refugees that she had worked with had been traumatized and had lost personal power in the process. Yoga provided the self-awareness and the ability to step outside the emotional self as a witness, thereby enabling rational decision-making and a sense of control over one’s life. This process of empowerment was also referred to by Ava

and Lyla, both yoga therapists, who spoke about the sense of control that yoga provided to refugee participants as a tool to manage their own symptoms. Lyla used the phrase, 'I did this to improve my health and I have achieved it', as reflective of the way yoga places the power of healing in the hands of the person rather than the traditional medical path where, as she said, 'everything is done to them'.

Many of the refugee participants referred to this sense of empowerment in different ways. Several of the Karen interviewees spoke about how they had been dependent on their children to walk on them in the traditional manner so as to alleviate their body pain issues. All of them said that they did not need to depend on their children for this anymore as they could do the yoga postures and breathing instead. As Dah Gay phrased it, 'I can look after myself now'. Several other participants also reflected on the sense of control the practices gave to their lives as they were no longer completely dependent on the hospitals and the doctors for their health needs. Neda referred to this, saying that she had a new routine of going out into the open air in a park and practicing yoga regularly and was able to deal with her sense of helplessness and depression through this routine. Musu also reflected on this new sense of control saying she felt good about attending the yoga classes because she had learnt 'how to do things by myself', a point of view shared with Zainab who also said that she experienced more confidence in going out and meeting new people after the yoga classes. Mu Dah also emphasized this new confidence as, 'I am braver and able to go out... and when I go out, I am not that scared'.

The sense of control and empowerment is also reflected in the fact that several of the participants taught the practices to their families. Paw Say taught her husband and several others taught their children. Mu Dah said that her young son initially saw her practicing and said, 'are you silly, mom', but had then joined her in her practice. This aspect was also spoken of by one of the yoga therapists (Lyla) who said that her opinion was, 'that if you help the women you are empowering the whole family'.

Yoga as group therapy. As discussed earlier in Chapter 3, loneliness and alienation are a common issue for refugees settling in Australia, with the attendant loss of family and social networks as well as the loss of resources to develop new networks (Babacan and Gopalkrishnan 2005; VFST 2007; VDHS 2008). To many of the participants, regular attendance at the yoga classes was a way to meet new people

and enjoy developing new relationships. Josephine spoke about this when she said that if she stayed at home she used to get stuck into one way of thinking, often a depressed or negative frame of mind whereas, by going to class, she was able to exchange ideas with the others in the group and feel happier. This sense of happiness and enjoyment of the yoga class as a social occasion was reflected by many of the other participants and, as Mu Dah said, they 'were able to talk and have fun together and are happier, and don't suffer like [they] used to'. Even Dah Gay, though she had a medical certificate to stay home from English classes and interviews, said that she preferred to come to the yoga class because she felt better there.

Another aspect of yoga classes as group therapy was spoken of by Olivia who ran her yoga classes on lines similar to the medical model of group therapy that she uses in her psychiatric practice. She pointed out that people were able to share their physical and emotional issues at the beginning of the class and so there was a common understanding of what could be accomplished in the group. A similar process was also spoken of by Ava who used the presence of the interpreter to ensure that any issues and problems were shared at the beginning of the class and that the class could then incorporate techniques to deal with those issues.

Olivia also asserted that the group would work better if people of similar cultural backgrounds practiced together as that reduced issues around language as well as improved several aspects of group processes and the building of friendships between participants. This issue was also raised by Ava who found it easier to work with her group because they were all from one community and spoke the same language. Shakti, on the other hand, struggled with her group to some extent because they were a very diverse group and she spoke of a number of issues relating to language, approaches to time as well as levels of interest which, she suggested, were culturally biased. Ler Say also reflected on the effectiveness of a group class where the participants shared similar cultural backgrounds as well as similar issues in terms of the traumatic experiences and said that these factors were important to the healing process.

Yoga as support for other therapists. As described in Chapter 4, many people in the helping professions, especially counselors and psychiatrists, can become very involved in the needs of their clients, and may not pay enough attention to their own

physical, psychological and emotional health (Garland 2010). This can have serious impacts on the outcomes of therapy as has been documented in several empirical studies (Addison 2002). One of the yoga therapists in this study, Lyla, raised this issue in the context of the trauma service she worked in, saying that counselors and psychiatrists who work with refugees hold a lot of the pain within themselves. She argued that yoga could work well as a support in terms of releasing this pain. Mia also spoke about the experience of running yoga classes for the counselors of the service and affirmed that they were very useful for the health of the counselors as well as enabling them to understand the benefits of yoga practice. These statements correlate with Garland's (2010) findings that yoga can provide a self-directed system of healing for professional working with refugees, using their own practice to help with their own physical, mental, emotional and spiritual well-being as well as helping them to provide the best possible outcomes in the therapeutic process

Short term results only. Two of the participants stated that they did not get any lasting changes from yoga practice. Dah Eh said that she experienced relief for her issues of body pain and breathing difficulties only as long as she attended the classes. As she described it as

I always get these and yes, going to the exercise classes really helps me, when I move in there, but once I get home it starts again. And in the class we learn that if you get, you know, anything, pain at all, you know, before you go to bed you can sort of, do the breathing or relaxation so that you can - you will feel yourself in the bed very heavy and then you will fall asleep. But when I was doing that I feel so tight that I, you know, I had breathing difficulties then. Like my chest was getting tighter and tighter.

Kesi also said that she did not practice yoga any more as it did not benefit her enough. She had issues with lower back pain and with heart palpitations and she suggested that the effects of yoga were only temporary. She said that she had practiced yoga in the class but had not felt well enough to practice at home as she always felt tired and lethargic. She considered that the crafts classes run at the same Centre were more beneficial for her. This point was also raised by the yoga therapist of her group, Shakti. She stated that the yoga program was offered to all the participants of the Lifeskills program being run at a settlement agency and that some

of them had confirmed that crafts were a better therapy for them while others had chosen yoga instead. Her observation was that some of the participants preferred working with crafts like basket weaving as they were familiar and comfortable with these practices from their home countries. She pointed out that this raised the need for a bundle of approaches for people to choose from, in terms of those they feel most comfortable with.

Negative effects. As recounted earlier in this chapter, despite direct questions in this context, none of the participants in the interviews or in the focus groups had experienced any negative effects of the yoga practice, a finding that correlates with much of the evidence in the literature (Penman, Cohen et al. 2008).

Yoga as CAM/Integrative Medicine

Medical Plurality: The process of Complementary and Alternative Medicines working together with Biomedicine is part of our daily lived reality, as discussed earlier in Chapter 3. CAMs are widely being used by the general population in Western countries and integration of these modalities with biomedicine is increasingly occurring, either through patients integrating CAMS and Biomedicine into their own personal health plans or through medical practitioners integrating CAM modalities into their practice (Libster 2001; Andrews and Boon 2005). The respondents in this study gave accounts of being very comfortable with using multiple modalities of healing and were very practical in their approach to healing. Almost every participant stated that they needed to take the medicines as prescribed by the doctors as well as practice yoga and utilize other CAM approaches such as Massage and Herbal Medicine. The majority of the participants pointed out that each of the modalities had their strengths and weaknesses and that by availing of several of them at the same time, they were able to get the most health benefits. This view was emphasized by Mahtab, who asserted that Western medication was very useful for her up to a point. She stated that it helped to make the sickness better but did not get rid of the source of the problem. She maintained that yoga was better for her along with the medication because the problem was then removed from her body. Similar sentiments were expressed by Naw Wah when she said

Because at the moment I have to take the medicine that the doctor gave me, then I also take the herbal medicine from [torture and trauma service] and

I'm doing the Yoga and... all these three things put together so I'm able to come here today... with the yoga class that I've doing, otherwise you won't see me here today.

Mu Dah reinforced this point when she said that she had a lot of suffering within her that she could not speak about until the practice of yoga along with some massage support gave her the confidence to open up and talk it out with the counselor. Several of the participants particularly pointed to their issues of pain as examples of how the different modalities needed to work together. As Zainab explained it, her doctor could not identify the cause of her back and neck pain and was only able to relieve the symptoms of the pain by giving her pain killers. She argued that she was able to deal with the problem in a more effective way by regularly practicing yoga along with using her pain medication when she had acute problems. This method of combining modalities into a personal integrated plan of health was a thread that ran through almost all the interviews with refugee participants. The openness of refugee participants to multiple healing modalities was also reflected in the interviews with service providers and with complementary practitioners as well as in the focus groups as discussed in the previous chapter.

Integration: The pragmatic approach to integrated medicine at the individual level also raises the dire need for integration at the system level. If the different practitioners are not working together with each other there is a clear danger of drug interactions and negative reactions, not with CAMs like yoga, but certainly where biomedicines and herbal medicines are prescribed at the same time (WHCCAMP 2002). Integration and teamwork can avoid this danger as well as ensure that all the concerned practitioners can work with the client with the assurance that there are no hidden pathologies and issues that they were not aware of, an issue raised by Erin as a complementary therapist and discussed in the previous chapter.

The yoga therapists also drew from their experiences to discuss the issues of yoga working in an integrative model with Biomedicine and other CAMs. Shakti drew on her ten years of experience running a Yoga Therapy Centre that incorporated several medical doctors as well as a naturopath, masseuse and an acupuncturist in the practice. She pointed that the first point of integration was in diagnosis, where she, like Erin, argued that biomedicine had the tools to determine all the physical aspects

of disease, and that the results from these were then used by the different practitioner along with their own diagnosis systems. The different practitioners then, along with the client, worked closely to determine a health plan for the individual. She maintained that this system rested on the openness of the medical doctors to therapies like yoga as well as the experience and knowledge they had of the other therapies as that determined how effectively they could work together with other modalities.

This aspect of the knowledge and experience of the medical doctors as the determinant of the success of an integrative practice was also raised by Erin when she said that education of biomedical practitioners and counselors to the content and benefits of CAM approaches was a key component of an integrative practice. Mia, as a yoga therapist, spoke of this in terms of her experience with one of the counselors in her service that was most resistant to the idea of yoga as therapy. It was only after he joined a yoga class run for the counselors and experienced the benefits for himself that he came around to work closely with the yoga therapist towards improving the health of refugees in the camp. The other side of this picture was the issue raised by a medical practitioner, Phillip, who argued that CAM practitioners needed to be educated in many of the biomedical concepts, so as not to overlook critical health issues that the client may have. He also drew on his experience to suggest that many CAM practitioners could be the responsible for creating health problems for their clients if they did not understand the real nature of mental health issues that the clients were suffering from.

Shakti focused on the integration of yoga with other healing modalities, reflecting the views that many of the refugee participants had spoken of. She asserted that yoga worked very effectively with other therapies purely because they all have different areas of focus and different strengths and they complement each other in terms of their effects. She gave the example of a client who practiced yoga and Chi Gung in tandem to achieve effects that she was not able to achieve with yoga alone. As she put it, ‘Yoga will open your awareness to what you need really, and if you need another therapy, they will work together.

Yoga and Psychiatry/Counseling: The relationship between the practice of yoga and those of psychiatry and counseling were spoken of in some detail by Olivia, who practiced both yoga and psychiatry as healing modalities. She argued that yoga

provided a program that was not dependent on the Western models of thinking. As an example she spoke of Cognitive Behavior Therapy where one is taught to argue with any irrational thoughts and gain dominance over it, whereas in yoga one just accepts the reality of the irrational thoughts in what is known as the 'Monkey Mind' (the viewing of the mind as an irate monkey that will not sit still and jumps from place to place) and to continue with one's practice. She argued that the effect of this practice is that the thoughts that were in the foreground and occupying center stage become smaller and less important. She recounted the benefits of yoga to her patients as

I don't have to spend hours, as a psychiatrist, talking about people's irrational feelings. You just say 'Right, I hear what you're saying and let's do the practice'. It saves time in the healing process as it doesn't seem to matter what sort of problems they come in with, they all leave the yoga class a lot more peaceful and the patients are - many of the patients in the class have been coming now for eight years very regularly, so they obviously find benefit from it otherwise they wouldn't come.

The relationship of yoga with the psychotherapy and counseling was also explored by one of the yoga therapists. Ava pointed out that sometimes the provision of an explanation of the causes of distress is not enough for the client. As an example she said that a conversation about, 'Your palpitations are connected to the state of tension or stress or anxiety' may not be enough to convince a client whereas an experience of going from getting the palpitations all the time to one of getting them infrequently or not at all through the practice of yoga can be very convincing and concrete. She believed that yoga and counseling worked really well together, a point of view shared by a complementary practitioner, Neva, who maintained that when people were stuck in counseling, yoga would help to unstick them.

Ava also reflected on the fact that, as a yoga therapist, she was not trained to provide psychosocial support and would not be able to respond appropriately when people would raise issues outside her area of expertise. She pointed out the advantages of an integrated service in these situations, where all she had to do was refer the client to the appropriate counselor. This, she considered, was an excellent reason for different therapies to work together, providing support to each other and to the client in the process.

Participation in Yoga Classes

Process and objectives of joining yoga classes: The participants in the yoga groups had entered the programs through different paths but generally they were already clients of the organizations running the yoga classes. In the case of the Melbourne yoga group, Ava, the therapist, stated that all the participants were clients of the torture and trauma service and had been referred to her program by the counselors of the service. The Brisbane participants were offered the yoga classes as part of a life skills program to improve the engagement of refugee women, being run by the settlement agency there. Two of the participants who had participated in yoga classes some time before this study said that they had joined the classes as they were already utilizing other services at a community agency and that yoga classes had been offered to them there.

The majority of the refugee participants had joined the yoga classes to deal with the range of health issues that they suffered from. Most of them spoke of chronic pain issues as the urgent need that had caused them to join while several mentioned insomnia, anxiety and breathing issues. Three of the participants also mentioned weight loss as the main reason for joining, though one of them, Musu, related the need for weight loss also back to chronic pain issues in her knee. The need to deal with health issues was not always spoken of as an objective in itself but one that helped many of the participants to become fully functioning individuals in society. As Naw Wah expressed it

For me I always like exercises and so when I join the Yoga class, I really enjoy it and it makes me happier. My aim is to get better and healthier so that I can continue on with my studies and learn English. And once I am able to learn English, I will work.

Gender. As described in Chapter 1, all the refugee participants in this study were women, on the lines of the evidence in the literature that the majority of yoga practitioners in the West are women (YJ 2008; SPARC 2009; ABS 2010). While a Yoga Journal survey discussed the differential rates of participation based on issues such as fear of embarrassment, inadequacy in terms of physical and competitive challenges as well lack of knowledge about the effects of yoga (YJ 2008), this study identified a range of other issues that were responsible for the men not participating in the classes.

Two of the yoga therapists, Ava and Lyla, argued that cultural issues were the reason that men did not participate. Lyla said that one man had actually joined the class for one session, but that the women participants had made it apparent to him that he was not welcome and he did not return. Ava spoke to the women participants before the classes began about the possibility of men participating. The participants stated that they would not be comfortable with a man in the room and had suggested that men would be better off in a men's group with a male yoga therapist and women with their own group with a female yoga therapist. This point of view was also spoken of during the interviews by several of the women refugee participants, reflecting discomfort at doing any of the poses that involved lying down or leg-raising in a mixed class. Hasina said that she would not have joined the class if it had men as participants. In the context of yoga classes for men that her organization planned to run, Lyla said that the gender of the therapist was also an issue. The male participants did not want a female therapist, and they had had to organize a male therapist for that class.

Some of the other reasons for lack of male participation that the yoga therapists suggested include the timing of the classes (during the middle of a weekday), which could have been an issue for many of the men who were already working, that some of the men were suspicious that yoga had religious connotations, and that the men seemed to prefer activities like soccer that were more physically challenging. Both Ava and Rez also spoke of the fact that their organizations found it very difficult to engage men in any activities that involved health and that the men seemed to leave all the health needs to the women.

While many of the refugee participants did not want men in the class, they all maintained that yoga was something that would benefit the men from their communities. Many of them pointed that the men also had similar health issues as theirs, such as chronic pain, breathing difficulties and depression and could benefit from doing yoga practices. Several of the participants said that they had gone back home and had taught their husbands some of the yoga practices to help them deal with issues of body pain. Paw Say spoke about this at some length, reflecting on the fact that men were losing out because they did not know about yoga and did not know what to do or how to do it. She recounted the fact that her husband had chronic back pain and that she had got him to practice alongside her at home and it had

relieved his pain significantly. The lack of participation of men was also discussed at the focus group of service providers, and the majority of participants asserted that men were not being engaged enough with health issues. They suggested that programs be tailored specially to men's needs and that this needed to be communicated more effectively to the relevant communities.

Perception of yoga as exercise. Almost every one of the refugee participants came into the yoga classes viewing yoga as a form of exercise, while often appreciating the mental and other benefits. Several of them spoke of being involved in some form of exercise or the other even in the camps, such as skipping or hard physical work, and maintained that their lives in Australia were lacking the physical element. Others said that they had started putting on weight after coming to Australia as a combination of a relatively sedentary lifestyle and change of diet. Yoga provided an opportunity to satisfy their physical health needs and this was given as one of the reasons for joining the class.

While many of the participants also described the health benefits that they experienced as being beyond the physical, most of them continued to refer to it, even after completing the course, as a form of exercise. Ava, as a yoga therapist, also made mention of this, saying that she found that she had needed to focus more on the physical postures and breathing patterns rather than the more complex meditation routines as she considered that her group was more interested in the former and seemed to derive more benefit from them. As she put it, 'if the group was described as a relaxation group or a meditation group it would not have the same appeal'.

Yoga as religion. This issue was specifically raised with the participants as there is a school of thought that connects yoga to Hinduism and argues that it should not be practiced by those following other religions (Scott 2001). None of the refugee participants made this connection. They did not see any aspect of religion in the practice, and several of them had actually combined the practices with their own religious practices of prayer and chanting. Olivia, one of the medical practitioners who taught yoga to people with trauma, spoke of the connection of religion and yoga as

Yoga is a spiritual path as well that helps people to become more connected with their spiritual needs, and it doesn't seem to matter what denomination or

anything people are. Whatever they are, the yoga seems to make them more connected to that.

Lyla, as mentioned earlier, did say that the men, who did not participate, were suspicious whether there were any religious aspects to yoga. However, none of the yoga therapists pointed to any issues relating to this during or after the classes. Mia, another of the yoga therapists, also said that she ensured that the counselors assured the participants that the yoga practice did not involve any religious teaching.

Content and Process of the Yoga Classes

Yoga as practiced today draws from a number of lineages, each of which has its individual focus and practices as delineated previously in Table 4.1, Chapter 4. Some of these lineages or schools of yoga are more suited than others to the practice of yoga as therapy depending on the nature of the practices incorporated as well as the ways in which these are practiced (Galantino, Galbavy et al. 2008). The yoga therapists interviewed in this study either came from or were influenced by two major lineages of yoga, those of Swami Satyananda and of B. K. S. Iyengar, both of which are lineages noted for their focus on the therapeutic applications of yoga. The four yoga therapists and one medical practitioner, who was also a yoga therapist, were able to draw out the key aspects of their practice that they considered were useful to participants of refugee backgrounds, and these aspects are presented in this section.

Structure of the class: The yoga classes in both Melbourne and Brisbane were run over eight weeks, with one class each week. All the therapists had incorporated physical postures or *Asanas*, breathing techniques or *Pranayama* and relaxation techniques such as *Yoga Nidra* (yoga sleep). The order of the techniques in class varied depending on the focus of the individual therapist or what they had assessed as the needs of that particular class. As an example, Mia described the way the structure of the class changed with her realization that the needs of refugees in Thailand were very different from the needs of Western students. As she described it

I started with more rigorous postures (still 'easy' by yoga-at-the-gym standards) and eventually realized that no one was looking for a good workout. And many were too sick/injured to stand. Many are malnourished. Culturally exercise is what you do all day on the farm. So

instead we emphasized breathing (3 part breath, hand on stomach), gentle postures and then progressive relaxation. That worked best.

While this class began with breathing techniques followed by postures and then by relaxation, all the others described a class structure beginning with the physical postures followed by breathing techniques and then relaxation techniques. All of these were generally incorporated within a time frame of forty five minutes to ninety minutes, depending on the time available to the therapist and the participants.

Method of practice: The postures in yoga can be practiced as static, maintained for longer periods of time, or as dynamic, when the practitioner moves from position to position relatively quickly using interconnected postures called *Vinyasas* (Desikachar 2005). Olivia stated that in her practice the focus was initially on the static approach but that they had found that these were not appropriate for survivors of trauma as they seemed to increase pain and stress. They had then adopted the dynamic *Vinyasa* approach with considerable success as they allowed the participants to go in and out of the poses and build up strength in the process. Ava and Shakti, both from the Satyananda lineage also utilized a series of slow dynamic practices called the *Pawanmuktasana* (energy release) series and the *Shakti Bandhas* (energy locks) but supplemented them with simple static poses practiced in a very gentle manner. Lyla also spoke of gentle practices but mainly focused on static poses. There was a consensus that the practices had to be such that they were simple and not physically taxing and, as Mia said, they enabled all the participants to feel good about themselves with no feelings of ‘I can’t do that’. Several of the participants said that the easy flowing movements were really useful in that they could be learnt easily and practiced at home more often.

Another aspect of the practices that was raised by several of the therapists was that of alignment. The Iyengar lineage pays considerable emphasis on correct alignment of the body to the desired posture and even uses props like belts and block towards this end (McCall 2007). The yoga therapists interviewed in this study had differing views on this. Mia asserted that the focus on correct alignment was very important for the participants in her class and she had even gone back to retrain further in the Iyengar tradition towards improving her practice for teaching purposes. She maintained that

this approach could still be inclusive for those with different health issues by modifying the postures to make them accessible. Ava, on the other hand, argued that too much focus on precision and alignment was detrimental to refugee participants. As she explained it

I think that too much focus on precision is anxiety provoking for a lot of people because they worry that they're getting it wrong. I really strongly emphasized the breathing with every pose and I - whenever introduce any new students I say the most important thing is not how well you do the pose, it's your awareness of doing the pose and remembering the breathing, and being aware of your own limitations. So in some ways I think the most common thread that's the most beneficial through all is just increasing that self-awareness, but also learning different ways to regulate pain or anxiety or something. The most important thing is... the insight they have themselves during a class. They're doing something afterwards, that they felt better.

All of the yoga therapist interviewees emphasized this importance of connecting the breath with movement during yoga practice to enable the participants to develop self-awareness, focus and concentration. They all spoke of the need to develop the awareness of the slow steady breath and through this awareness move towards relaxation and relief from stress.

In terms of the *pranayama* breathing practices, all of the therapists spoke of keeping them simple and avoiding strenuous applications. Breath retention was not recommended as it was seen as too strenuous. Some of the practices commonly mentioned included *Anuloma Viloma* or alternate nostril breathing and *Ujjayi*, or throat breathing, and several of the therapists stated that the focus needed to be slowing the breath down and using counting as a method towards this end.

Yoga Nidra: Yogic sleep is a powerful relaxation technique combining visualization, affirmation and relaxation used by several of the therapists as part of their practice. Ava and Shakti both spoke of the effectiveness of this technique in terms of developing a sense of self-awareness as well as relaxing the body and the mind at a very deep level. However they also raised some issues with its practice. The first

was, as will be further discussed later in this chapter, the need for an effective interpreter to communicate the concepts involved in the practice. The second issue related to some of the participants who were hyper alert and agitated due to their prior experiences of trauma. Ava found that, in such cases, it was useful to give participants the choice of keeping their eyes open during the practice. This eased the situation for the participants who then closed their eyes only when they began to be comfortable after a few classes. Shakti also confirmed that, where participants were traumatized, visualization should be avoided and the practice restricted to those aspects of relaxation that emphasized the physical body and self-awareness.

Involvement of Interpreters: As discussed earlier in Chapter 4, there is a view that yoga can be taught to refugees, despite a language barrier, by using demonstration as the major tool of communication and relying on copying, experiencing, exploring and self-regulating as the process of yoga learning (Saraswati 2010). The majority of the yoga therapists in this study, however, affirmed that the presence of a good interpreter was essential to the success of a yoga program. Both Shakti and Lyla had run yoga classes with participants from different cultures and speaking different languages. Shakti had used demonstration as a teaching tool but considered that not being able to communicate effectively through an interpreter impacted on the outcomes of the classes. She pointed out that those who spoke better English or had colleagues who could interpret for them benefitted more from the classes than those who had to depend on demonstrations to learn. She also referred to areas like the practice of *Yoga Nidra* and relaxation as being in the ‘too hard basket’ without an interpreter. Lyla, on the other hand, recounted that they had tried using interpreters at times but it was not technically feasible as the group was so mixed. She stated that the lack of interpreting was not an issue as they were able to manage with ‘sign language’ and lots of demonstration.

Both Ava and Mia had consistently used interpreters for the classes and confirmed that they were able to communicate effectively because of that. The communication was not just that of guidance from the therapist to the participant but also involved the participants communicating their thoughts, needs and issues to the therapist before, during and after the class. As a participant in the classes, Ler Paw said that it was of great benefit for her to be able to speak of her issues through the interpreter

before class so that the therapist could then help her out with them during class. Mia reiterated that the presence of interpreters was important to communicate significant ideas such as the benefits of each practice and the non-religious nature of yoga, as well as to be able to listen to the voices of the participants. Both Ava and Mia stated that having the interpreter was very useful in terms of effective communication as well as in ensuring that cultural issues were kept in mind and that no boundaries were crossed. These comments are also reflected in the literature where, as Tribe (2005) argues, interpreters provide the dual function of communication and as sources of cultural knowledge and understanding.

Regularity of Home Practice: Many of the participants found that the effects of the yoga practice were magnified considerably if the practice in class was supplemented by regular home practice. All the yoga classes whose participants took part in this study involved one class a week. As discussed earlier in the section on yoga as group therapy, there were multiple benefits to the group class and several of the participants reflected on the difficulty of being able to practice alone, giving reasons like lack of motivation, the cold of winter or the heat of summer, forgetting and not having the time. However, those who were getting immediate benefit from their practice in terms of relief from pain and insomnia like Hasina, Musu and Naw Wah tended to practice regularly at home.

The question of material to support home practice, such as handouts and compact discs, was also discussed and there was a consensus that at least handouts with the postures and explanations were very useful to enable the participants to practice at home. Neda, as a participant, spoke of using a book on yoga to continue her practice after the end of the classes. Ava, Shakti and Lyla, as practitioners, were all of the opinion that basic handouts were useful. However there was some difference of opinion around the use of compact discs as support material. Olivia asserted quite strongly that she did not want the participants in her class to become addicted to the sound of her voice. She considered that it was important for them to develop independence and for her to avoid 'spoon feeding'. She essentially wanted them to find their own ways and maintained that too much technological support detracted from that. Lyla however argued that compact discs in the participants' own

languages were very useful to enable them to practice at home. She had provided the participants in her class with such material and it had been quite useful

Frequency of Classes. All the yoga classes were run once a week and during the day, which were the arrangements most convenient to the participants. Most of the participants said that that was all they could manage as they also had other responsibilities including children as well as English Language classes. The cost of transportation was also raised by Josephine as a reason why she could not attend classes more regularly. While all of them said that while ideally they wanted to attend classes more often, they could not figure out how to make it possible. One of the yoga teachers, Lyla, suggested that participants would benefit by attending classes two to three times a week and her solution to the time constraints was that, given the right funding, she would run the classes every day and allow participants the flexibility to come to classes as per their convenience.

Child Support: Keeping the children, especially the younger ones, occupied during the yoga classes was an issue mentioned by Lyla. She said that they had help available from her organization at times but that there were times where this was not available and that created major issues in terms of practice. She gave the example of a young mother who continued breast feeding her baby while doing twisting postures in the class at the same time. None of the other yoga therapists spoke of this as an issue as child minding facilities were provided for the participants at the practice locations.

Settlement and Yoga Classes. All the refugee participants in the yoga classes had been in Australia at least a year. Ava spoke about the fact that health issues and CAM therapies are best utilized later rather than sooner in the settlement process. She pointed out that newly arrived refugees are far too busy juggling the medical assessments and acute health issues as well as housing and other resettlement issues that they have not time to engage with their chronic health issues. It is only after the initial difficult time is over, perhaps six to twelve months after settlement that they begin to deal with these health problems and where therapies like yoga would be useful. Several of refugee participants also spoke of the fact that it took them some time to get to dealing with their pain and other chronic issues as they were so busy settling into Australia.

Summary

In this chapter I began by excavating the health benefits from yoga practice that were described by the participants, and discussed the multiple benefits in light of the earlier discussion of complex health issues that were raised by them. Some of these benefits included pain alleviation, relief from sleeping issues, stress and anxiety relief, reduction of medicine dependency, improved levels of confidence and empowerment. A small minority of participants did not experience long term benefits from the practice of yoga and had completely discontinued the practice.

I then went on to present the interviewees' views of yoga as a CAM modality and to discuss the issues with its inclusion within an integrative medicine model of healing. I also reviewed the process by which many of the participants in the yoga classes came to join the classes and discussed the reasons for only women participating in yoga. The different aspects of content and process of the yoga classes was then presented including a focus on those that supported effective classes/therapy. The next chapter is the concluding chapter and brings together the literature and research into an analysis of the key issues and findings in light of the objectives of this study. The chapter ends with an outlook on the future and makes suggestions for ways forward.

Chapter 8: Looking Back/Looking Forward

Introduction

The central focus of this thesis was an exploration of how the health systems in Australia have responded to the health needs of refugees in the context of biomedicine and alternative medicines and the key research question was:

“What role can yoga therapy, as a complementary therapy, play in responding to the complex health issues of refugees settling in Australia?”

More specifically the research aimed to:

- i. Explore the perception of health of refugees settled in Australia among service providers and refugees themselves and the key factors impacting on this.
- ii. Examine the existing mainstream responses to the health needs of refugees.
- iii. Critically analyze the role that complementary therapies play in providing an alternative holistic framework for refugees, using yoga therapy as a special focus.
- iv. Develop strategies for future policy and practice for policy makers, refugee service agencies, health practitioners and refugee communities themselves

These are critical issues that impact on the ways in which health services respond to the health of refugees. This chapter will provide a review and analysis of the overall findings in relation to the key research questions and examine ways forward for future policy and practice.

Perception of health of refugees settled in Australia among service providers and refugees themselves and the key factors impacting on this.

The health of refugees

The refugees who participated in this study reported a complex set of chronic health problems. These included chronic pain, breathing issues, insomnia, physical tremors, palpitations, skin problems, flashbacks, cognitive issues, stress, anxiety, depression and PTSD. All the participants reported experiencing these issues as a cluster of conditions as has been widely reported in the literature (Bendfeldt-Zachrisson 1985; Kiesler 1999; Silove 1999). The problems the participants spoke of were mostly not of the intensity that they would require hospitalization, but were acute enough to have a major impact on their everyday lives, especially in terms of gaining employment or of engaging fully with their families and the community. The range of refugee health problems were confirmed by medical practitioners and service providers who dealt with refugee clients regularly.

This research excavated a regular thread of connection between physical and mental health issues, another aspect of the health of refugees that has been reflected in the literature (WHO 1996; NCTSN 2005). Many of the refugee participants as well as some of the medical practitioners and other participants clearly linked physical symptoms such as chronic pain and shortness of breath with anxiety, stress and depression and affirmed that many of the health issues of refugees were closely interconnected. As a corollary to this, the separation between physical and mental health systems was raised as a problem at several points through the interviews and focus groups by refugee participants, therapists and support workers.

In this study we found that refugees held complex and holistic approaches to health, shaped by their cultural traditions. The key findings, in summary, were:

Health as happiness- Many of the refugee participants viewed their health status and their sense of happiness as very closely linked or, in some cases, the same.

Connection between body and mind- Most of the refugee participants also indicated that the issues of the body and the mind were very closely connected. The

articulation of the nature of this connection varied from culture to culture and from individual to individual.

Faith and health- Several of the participants spoke of connecting to God or spiritual belief as part of healing and good health. While they were open to utilizing a variety of therapies for their health, they considered that this was one more way of working towards good health.

Environment and health- Both the physical and the social environment were reported as significant factors in refugee health and illness. Refugee participants, support workers, and some medical practitioners emphasized the social environment as particularly impacting on the health of refugees, a view also reflected widely in refugee health literature.

The refugee participants confirmed a plurality of views on health. The causes of disease as well as the nature of what constitutes good health are viewed differently across different cultures and these have impacts on the effectiveness of therapeutic responses to health issues (Papadopoulos, Lay et al. 2003; Helman 2007). These views of health by refugees appear to be in conflict with Western culture that is dominated by the biomedical model, where the focus remains on individual intrapsychic experience or individual pathology and the relationship of disease with singular causal agents (Tribe 2005).

Key factors impacting on health:

All the refugee participants in this study had experienced traumatic stress prior to migration, before and during their journeys to the refugee camps as well as, in many cases, in the refugee camps themselves. Some of the traumatic factors recounted included loss of family members, physical abuse, starvation, violence, as well as health and other issues without adequate systems to meet their needs. All of the participants had experienced displacement, loss of home and networks, and had experience of camp life and exile. Further, resettlement in Australia brought with it a new set of challenges that exacerbated many of their on-going health issues. Some of the key issues raised during this study included lack of English language proficiency and inadequacy of the available resources to attain this proficiency, alienation and loss of social networks, lack of information, problems with dealing with government and other agencies and systems, racism and other forms of discrimination,

employment and financial barriers and acculturation stress. This diverse range of refugee and settlement experiences were confirmed by refugee participants themselves, service providers, complementary therapists and medical practitioners who took part in this study.

This evidence from this research substantiates the existing literature about the experiences of refugees. In the models outlined by Aroche and Coello (2002) as well as by Beiser (1991) refugee health is an outcome of several factors of which traumatic experiences prior to resettlement and post settlement stress are very significant. The combination of these factors place refugees at a profound disadvantage to negotiate the complex demands of the exile, migration and resettlement processes (Brautigam 1996).

Impact of the existing mainstream responses to the health needs of refugees.

All the refugee interviewees had used the biomedical system in the form of doctors and medicines in their home countries and were familiar with the concepts of biomedicine. For those interviewees who lived in cities prior to coming to Australia, the medical doctors and the hospitals were the primary supports for dealing with their health issues. For those who lived in rural areas, as most of the interviewees did, health needs were met by a mix of medical doctors, village healers and local healing knowledge. The common thread that emerged through the majority of the refugee interviews was that they were used to a plurality approach towards dealing with their health needs. They spoke of treating themselves with home remedies and CAM practices like massage, followed by recourse to different types of healers depending on the convenience of access or the nature of the illness, where the Western doctor was often approached for acute physical ailments while other healers were approached for chronic illnesses or those which did not seem directly related to physical reasons.

Australia's system of health services focusing on the unique health need of refugees is widely documented in the literature (Correa-Velez, Gifford et al. 2005). Refugees entering the country go through two levels of pre-departure health screening as well as screening assessment and treatment in the initial period after resettlement in Australia, which can vary from six months to a year (Hale, Wood et al. 2006; Smith

2006). After this period, most refugees have to resort to the mainstream medical system for their health needs, depending on GPs and hospitals for their physical health needs and psychiatrists and counselors for their mental health needs. In some cases where chronic issues like PTSD have been identified, the person is able to avail of specialized services such as a refugee trauma service for a longer period of time (Correa-Velez, Sundararajan et al. 2007; QH 2008).

Once they had begun the process of migrating to Australia, all the refugee participants, except for Shalini, had gone through their health checks prior to coming to Australia. As Shalini's status changed from asylum seeker to humanitarian entrant in Australia, she had all her health checks in Australia. Further to this the refugee participants in this study had all gone through post settlement health screening at refugee-specific services and did not have to go to GPs or psychiatrists without knowledge of refugee issues in the initial period of settlement. All of them had then moved on to community general practitioners and to psychologists and psychiatrists who did not necessarily have an understanding of their specific situation and needs. Many of the interviewees reported that the doctors and psychiatrists in Australia were very good and had resolved many of their acute physical issues. Even where the doctors could not help them, many of them affirmed that the doctors had the right attitude towards them. All of the participants spoke of going to doctors repeatedly and for a long time for the treatment of the chronic problems that they had identified.

Despite a positive attitude by refugee participants a number of key issues raised which point to the problems refugees face in the biomedical systems. These included lengthy tests without diagnosis, frustration with appointment and other referral systems, lack of time by GPs and health professionals, issues of trust, cultural differences to health, side effects of prescribed medicines, communication barriers and lack of interpreters.

Another point of view expressed by several of the refugee interviewees was that doctors were very effective for some issues relating to the physical body but that 'mental health' issues or issues where the body and mind were connected were not so well managed through the medical system. When this is considered in conjunction with the fact that many of the refugee participants saw a close connection between body and mind, the clear distinction in Australia between the organizations that deal

with the physical health of refugees and those that deal with mental health presents a problem in terms of the health of refugees. This viewpoint was also reflected by some of the medical practitioners and support workers who, however, maintained that any integrated approach to replace the present system was a utopian option.

The findings of this study confirm that refugee participants have cultural traditions of pluralistic medicine. Their experiences identify difficulties with the biomedical models of health, although the majority saw the value of biomedical responses. The biomedical paradigm presents us with a range of issues in terms of the health of refugees; issues involving the understanding of health and illness, causality and healing, issues of the mind/body duality, reductionism and lack of complexity, power relationships and structures, all of which indicate the need for a framework that better accommodates difference. What this points to is a wish by participants to see greater pluralism in health service options and a more integrated approach to medicine and health. The perceptions of refugees and other stakeholders towards complementary therapies are of vital importance.

The role that complementary therapies play, with yoga therapy as a special focus

Role of CAM therapies

All of the refugee interviewees had used CAM therapies in Australia. The therapies they identified and used included Yoga, Naturopathy, Flower Essences, Homeopathy and Massage therapy. CAM practitioners also mentioned Acupuncture. Refugee participants valued both biomedical and CAM systems of healing and were utilizing them for different purposes. The study confirmed that refugees are accustomed and welcomed multiple healing modalities and valued them. They were able to selectively use medical and CAM practitioners based on their health needs. They demonstrated equal respect for health practitioners and referred to them as ‘doctors’.

Interviews with CAM therapists in this study confirmed that alternative holistic frameworks are beneficial to refugees. Practitioners who took part in the study identified that when people have been traumatized they are already in a state of dissociation and cannot integrate or feel different parts of their body. It was identified that the health system reinforces this separation rather than integrating them as one being, a whole person, and CAM took a holistic approach which took

account of the entire lifestyle of the person. Many practitioners argued that that Western medicine was very good at dealing with symptoms quickly for acute problems, but not so good at dealing with root causes. It was pointed out that CAM allowed people to be self-empowered and to self-manage, allowing them to develop skills for living. As such they could avoid being stuck in the health system in the long term and accordingly reduce the costs in the long term.

However, practitioners complained that funding was not available to run programs for refugees due to the domination of the biomedical model and the lack of funds being allocated to CAM treatment. As CAMs, in the main, are not part of the Medicare system, issues of access to CAMs for refugees is a major consideration. Some service providers affirmed that refugee clients were missing out on total health services as many could not afford to pay privately for CAM therapies. Hufford's (2002) views are pertinent here where he reflects on the hypocrisy of a system that sought to 'mainstream' members of different cultures into the acceptance of the biomedical model when the 'mainstream' patients were turning more and more to CAM approaches for their health needs.

It can be concluded that complementary therapies have an important role to play in providing a framework for refugees and will provide empowerment of individuals in determining their health and well-being. It is clear that refugees value having choices about different healing modalities and a pluralistic approach. This view has been supported by service providers, CAM practitioners and majority of the medical practitioners.

Yoga therapy as a focus

All of the refugee respondents had participated in yoga classes and had come to do so through different paths. The context of yoga classes has been identified as an important consideration for refugees, particularly women. They noted issues with gender composition of mixed classes and male yoga therapists. The timing of yoga sessions, frequency of classes, availability of child care, lack of interpreters, and barriers of transport was identified. This pointed to the correlation between settlement factors and when yoga therapy is accessed. The frequency of practice at home, beyond classes, is also closely linked to settlement considerations. Participants identified that it takes them 6-12 months after settlement to begin to deal

with chronic health problems as they are too involved with urgent issues of settlement before that. They suggested that therapies like yoga would be useful beyond that point.

Refugee participants saw yoga therapy as a form of exercise, connected to physical activity. Yoga therapists also believed that the more meditative elements of yoga did not have the same appeal as the physical. Participants did not hold perceptions of yoga as a form of religion and therapists ensured that there were no religious elements in classes. Some participants were able to combine practices from their own religion with yoga. These cultural and contextual considerations must be borne in mind if yoga therapy is applied to refugees so that they do not feel yoga as imposing.

Yoga therapy was, without doubt, effective for refugees in this study. All the refugee participants reported a number of benefits that they had experienced as a result of their participation in the yoga classes. Most of them reported the benefits as being long-lasting and, in many cases, helping them even after a month of the end of the classes. The multiple benefits were reported in areas of:

- Reduction in chronic aches and pains in the body
- Improved sleep patterns and reduction of insomnia
- Lessening of breathing difficulties
- Reduction in stress, anxiety and panic
- Better and more accessible coping mechanisms
- Reduction in dependency on medicines
- Empowerment

These benefits were confirmed by other stakeholders including settlement service providers and CAM therapists. Participants recognized that the process of yoga practice would bring outcomes gradually and that it was not a quick fix. There was a mix of long term and short term benefits of yoga therapy for various symptoms reported. No negative side-effects were reported.

Yoga therapy can provide the tools for refugees have self-determination and control. As CAM practitioners noted, yoga therapy can support counseling and go beyond talk based therapies through the demonstration of body-mind connections for

symptoms such as the link between anxiety and palpitations. CAM practitioners talked of the effectiveness of yoga therapy as a concrete way to work with clients which engaged them in physical and emotional ways.

Yoga therapy provides an invaluable framework for refugees through empowering practices such as the techniques and lifestyle that, once learned, enable the participants to practice at any point of time, and without dependence on any person or equipment (Young 2001). This enables them to develop a level of independence in terms of dealing with their health issues. Several of the yoga therapists spoke about this issue of disempowerment and the place that yoga has in terms of dealing with this problem. The empowerment methods and outcomes of yoga therapy is an alternative to the biomedical model of 'having things done' to people. The study confirmed, through the lived experiences of refugee participants, that empowerment took place, in different ways. Some of the examples cited included less dependency on family members, ability to go out into public spaces, freedom from pain, better coping abilities and increased confidence levels. A point made by one participant was valuable where she stated that the practice of yoga enabled her to voice her suffering and health problems, which she had not found possible before joining yoga. By articulating her health issues she was able to address them.

Ways Forward: Policy and Practice Considerations

CAM practitioners who took part in this study voiced the need for an integrated system of biomedicine and alternative therapies. They also raised issues of the resistance from health professionals in their services. The majority of medical practitioners in the study were supportive of using integrated models of medicine and healing but considered that the idea of an integrated system for the health of refugees was utopian at this point in time.

The findings of this study raise a number of considerations for the future of refugee health in policy and practice. Notwithstanding the fact that these are broad and complex issues and involve considerations of professional boundaries, profit sharing, power differentials and competing philosophies, the following key issues need to be addressed as ways forward:

- ☉ *Holistic focus on the health of refugees:* Groups such as refugees who are marginalized in society but are not statistically significant in a population can

easily fall below the radar. Many of the multicultural health areas of health departments have either been disbanded or reduced. While there is funding for broad refugee health issues, this is piece-meal and compartmentalized and the research and knowledge base for the health of refugees is limited. Additionally the service delivery for refugee health is delivered by non-government agencies or medical systems, often without connectivity between agencies. The separation between body and mind health systems is also a key problem area in responding effectively to the health needs of refugees. A more coherent approach is needed to address the health of refugees bringing together NGOs, medical and health practitioners, educators and researchers and CAM practitioners adopting an integrative medicine framework and working through partnerships. A holistic focus on the health of refugees would ensure funding flows to integrated approaches and would move away from the current marginalization of CAM therapies.

- ☯ *Yoga therapy in refugee health service practice:* Funding for yoga therapy and also for CAMs in general for the health of refugees is scarce. While these alternative approaches are recognized as useful by NGOs and refugee health services they are marginalized and not included as core funding in refugee health service delivery. Such alternative services are among the first programs to be cut down when funding is curtailed. Refugee health services need to advocate for better funding models for yoga and CAM therapies to ensure that they can be offered and accessed by refugees. Further there needs to be an extension of these programs to beyond the initial periods of settlement, i.e. more than 6-12 months. A better evidence base for yoga therapy and CAM (see below) will help build the argument for more programmatic funding for CAM and yoga therapy for refugees.

- ☯ *Recognition of yoga as therapy:* Yoga in the West is often treated as a form of physical exercise or method for relaxation. The therapeutic role of yoga is not well recognized. While there is evidence in clinical situations about the health outcomes of yoga therapy this needs greater integration in mainstream health practice. Yoga therapies have emphasized teaching and research to address different health problems. However, there are no specific yoga

therapies that research or train therapists in relation to the health of refugees especially in terms of working with trauma survivors. Yoga therapy curriculum and yoga training courses focusing on the health of refugees are needed.

- ☯ *Training and education of health professionals:* There is a need for better education of biomedical and CAM health professionals about integrated systems. This would need a review of curriculums of health education to ensure that biomedical health professionals understand and respect the value of complementary and alternative therapies. Conversely, CAM practitioners need to understand biomedical concepts, as well as methods to work in partnership with biomedical practitioners so as to provide the best possible health outcomes to the client.
- ☯ *Research and research funding for yoga therapy:* There is chronic underfunding of research in yoga therapy and this area is marginalized in terms of the research needed to demonstrate its effectiveness and efficacy towards dealing with the issues of the health of refugees. Governments and corporations need to put in more research funding. The evidence base for yoga therapy is critical as it will increase the legitimacy of alternative approaches, their adoption and benefits to refugees. By having a strong research and evidence base, there will be significant benefits in the future professional development of health and welfare services staff, program design and policy development.
- ☯ *Recognition in health policy:* Health policies treat CAMs such as yoga therapy as secondary. While health departments engage in regulation of CAM practice, the recognition of integrative approaches and the value of CAM in health are not recognized in policy. This has the flow-on effect of lack of funding, lack of promotion and the failure for integrated approaches. A first step to enable CAM in the structural integration in health systems would be the recognition of the place of CAM and medical plurality in health policy. Connected to policy issues is the need for CAM peak agencies and practitioners to be represented in key medical forums, reviews, advisory and

consultative processes of health departments for all areas of health issues, not just confined to complementary and alternative therapies. Additionally, government can lead the way and demonstrate best practice by utilizing integrative practice in the services it funds.

- ☯ *Promotion and awareness:* The comparatively new area of scientific CAM research does not yet have the general acceptance of university departments, statisticians, large databases and policy makers. While there is increasing uptake of CAM in the general population, there continues to be misinformation and lack of recognition of CAMs. Greater promotion will improve public understanding and engage the broader health industry to engage with integrative practices.
- ☯ *Modification of yoga practices to support the health of refugees:* Yoga therapists and teachers need to consider the special needs of refugees when working with them. Many of these are discussed in chapter seven and range from general concerns such as the use of interpreters and issues of gender, to more specific yoga-related ones such as the use of dynamic practice as against static practice. All of these require careful consideration to ensure that the yoga practices adopted are suitable to support the complex health needs of refugees.

These strategies are interlinked and the outcome of one can impact on the other. The health of minority groups in our population, such as refugees, is critically linked to the kind of society we want to develop. It is a reflection about the compassionate nature of our society, the philosophies and systems we hold in relation to health and well-being and the systems we build to support the needs of individuals and communities. Access to holistic, integrated health systems for people who are marginalized, such as refugees, is a matter of social justice. As discussed by the participants in this research, yoga therapy can offer a humanistic, compassionate and empowering support for one of the most vulnerable groups of people in Australian society- refugees.

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Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

Appendix 1: Ethics Approval

**Human Research Ethics
Committee**

TELEPHONE 9266 2784

FACSIMILE 9266 3793

EMAIL hrec@curtin.edu.au

memorandum

To	Professor Linda Briskman, Dr Haruhisa Handa Centre for Human Rights Education
From	A/Professor Stephan Millett, Chair, Human Research Ethics Committee
Subject	Protocol Approval HR 19/2009
Date	08 April 2009
Copy	Narayan Gopalkrishnan (14 Clematis Court, Cashmere, QLD 4500), Graduate Studies Officer, Faculty of Humanities

Thank you for your application submitted to the Human Research Ethics Committee (HREC) for the project titled "Yoga Therapy and the Health of Refugees". Your application has been reviewed by the HREC and is approved.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 19/2009**. Please quote this number in any future correspondence.
- Approval of this project is for a period of twelve months **07-04-2009** to **07-04-2010**. To renew this approval a completed Form B (attached) must be submitted before the expiry date **07-04-2010**.
- If you are a Higher Degree by Research student, data collection must not begin before your Application for Candidacy is approved by your Divisional Graduate Studies Committee.
- The following standard statement **must be** included in the information sheet to participants:
This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 19/2009). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **FORM B** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development:

When the project has finished, or

- If at any time during the twelve months changes/amendments occur, or
- If a serious or unexpected adverse event occurs, or
- 14 days prior to the expiry date if renewal is required.
- An application for renewal may be made with a Form B three years running, after which a new application form (Form A), providing comprehensive details, must be submitted.

Regards



A/Professor Stephan Millett
Chair Human Research Ethics Committee

Appendix 2: Consent Form for Participants Involved in Research- Interviews

Yoga Therapy and the Health of Refugees

You are invited to participate in a research project entitled: **Yoga Therapy and the Health of Refugees**. This project is being conducted by Mr. Narayan Gopalkrishnan, supervised by Prof. Linda Briskman, towards the completion of a PhD thesis from Curtin University.

CERTIFICATION BY PARTICIPANT

I, _____ of _____

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study:

Yoga Therapy and the Health of Refugees, being conducted by Professor Linda Briskman and Mr. Narayan Gopalkrishnan.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to being carried out in the research, have been explained to me by Narayan Gopalkrishnan, and that I freely consent to participation in the interview:

- involving the collection of general demographic and background information with no specifics that can be used to identify me,
- Discussion on my perceptions of health, the medical and other support I have experienced/ I support, and my experience of yoga therapy/ views on yoga therapy, and my views on future strategies to benefit the refugee community in terms of health,
- Recording of interview for transcription purposes.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardize me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Date:

Any queries about your participation in this project may be directed to the researchers:

Professor Linda Briskman tel. 08-92667186

Mr Narayan Gopalkrishnan tel. 07 38821332, mob. 0412157084.

This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 19/2009). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Appendix 3: Consent Form for Participants Involved in Research- Focus Groups

Yoga Therapy and the Health of Refugees

You are invited to participate in a research project entitled: **Yoga Therapy and the Health of Refugees**. This project is being conducted by Mr. Narayan Gopalkrishnan, supervised by Prof. Linda Briskman, towards the completion of a PhD thesis from Curtin University.

CERTIFICATION BY PARTICIPANT

I, _____ of _____

certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study:

Yoga Therapy and the Health of Refugees, being conducted by Professor Linda Briskman and Mr. Narayan Gopalkrishnan.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to being carried out in the research, have been explained to me by Narayan Gopalkrishnan, and that I freely consent to participation in the Focus Group:

- involving the collection of general demographic and background information with no specifics that can be used to identify me,
- Discussion on my perceptions of health, the medical and other support I have experienced/ I support, and my experience of yoga therapy/ views on yoga therapy, and my views on future strategies to benefit the refugee community in terms of health,
- Recording of focus group for transcription purposes.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardize me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Date:

Any queries about your participation in this project may be directed to the researchers

Professor Linda Briskman tel. 08-92667186

Mr Narayan Gopalkrishnan tel. 07 38821332, mob. 0412157084.

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Appendix 4: Interview Guides

Refugee Participants

Four Sections:

1. Demographics and background
2. Settlement Experiences
3. Health
4. Yoga

Lead in with statements of focus of project (medicine and yoga) and also why background is needed, cover ethical issues about voluntary participation, distress, withdrawal options during interview, confidentiality and permission to record. Consent form. Provide researcher self-disclosure. Explore with open- ended questions, letting participant lead.

Demographics and Background:

Areas to be explored:

- Gender
- Year of arrival
- Category of visa
- Cultural and other background
- Family
- Education status
- Employment status
- Written and spoken English
- Careful exploration of experience prior to coming to Australia with after checking with participant on willingness. Possible areas include journey, experience in camps, health issues and impacts.

Settlement Experiences

Explore

- Settlement stages
- Employment
- Language
- Housing
- Familial networks
- Racial attitudes
- Identity
- Culture
- Information sources
- Social and support networks and anything else that participant wishes to talk about.

Health

Explore:

- Present health status as perceived by participants.

- What is good health?- Cultural perspectives of health
- Dealing with trauma.
- Country of Origin Health Experiences: What did they do to keep good health? Explore experiences with health systems at this point in country of origin including biomedicine and any other forms of traditional/CAM modalities. Also explore cultural practices that support health.
- Refugee Journey Health Experiences: Continue same discussion through journey to Australia.
- Health Experiences in Australia: Health systems experience in Australia. Also explore cultural practices here that support health. CAM experience in Australia.

Yoga

Explore:

- Reasons for joining and prior views/experience
- Experience of the practice both negative and positive
- Outcomes of the practice both in terms of health and general lifestyle. Discuss in the context of earlier description of good health/cultural practices
- What was useful and what was not. Look at issues of composition, language, location, time and whatever else arises.
- Level of incorporation in day to day life (explore home practice)
- Discuss views on appropriateness of yoga within mainstream systems and other recommendations.

Interview Guide: Other Participants

- Explore background to involvement with refugees and professional role.
- Discuss perception of settlement issues of refugee clients, such as employment, language, housing, networks, racism and culture.
- Discuss health issues of refugee clients and the relationship with prior experiences before coming to Australia. Probe for views on how health is perceived by their clients.
- Excavate what specific health interventions are provided and their effectiveness.
- Explore professional's perception of the adequacy or otherwise of the present health system and how it supports/does not support the identified health needs.
- Discuss views on CAM approaches and experiences with refugee clients in this context.
- Explore the constraints and facilitative factors of CAMS systems including funding arrangements.
- For yoga therapists explore in detail outcomes, logistics, interpreting, specific practices, issues and problems. Discuss in the context of other CAMS as well as biomedicine.

Appendix 5: Focus Groups' Details

Focus Group	Location	Number of Participants	Issues Canvassed
Focus Group 1: Refugee Participants.	Melbourne	8	<ul style="list-style-type: none"> → Refugee experiences → Settlement Experience → Health and Well Being issues → Interfaces with Health Systems → Experiences with Complementary therapies → Experience of yoga
Focus Group 2: Support Workers (from diverse agencies offering settlement support to refugees)	Melbourne	7	<ul style="list-style-type: none"> → Barriers to settlement → Access and Equity in Health → Health experiences of clients (physical and mental health) → Attitudes to complementary therapies → Issues with Health systems → Yoga Therapy → Good practice examples

Appendix 6: Biomedical Health Services for Refugees, by State

State	Summary of Health Services	State Funding
Victoria (29 per cent of national intake) ¹	<ul style="list-style-type: none"> Part-time specialist refugee clinics at Royal Melbourne and Royal Children's hospitals and Dandenong Hospital Part-time Vitamin D Clinic at Western Region Health Centre Refugee Health Nurse Program Refugee Dental Services Program Victorian Refugee Health Network. 	All services listed are funded by the State ² .
New South Wales (28 per cent national intake)	<ul style="list-style-type: none"> NSW Refugee Health Service has a clinical role but also supports mainstream health services to assist refugees It runs three General Practice clinics. These give recently arrived refugees an initial contact with the health system, through a medical practitioner with a special interest in refugee health, and with a health care interpreter. A General Practitioner and Registered Nurse staff each of the clinics, and conduct initial investigations and provide referrals to other outpatient clinics. Services are provided free of charge to all refugees There are two pediatric clinics that provide services for refugee children in New South Wales, in the Hunter Valley and at Westmead Hospital in Sydney (these are State funded). Refugee Health Nurse Network 	NSW Refugee Health Service comprised of: -Director -Programs Coordinator -Policy and Project Officer -GP Liaison and Projects Worker -Health Information Program Coordinator -Human Resources Development Officer -2 Registered Nurses 2 Sessional General Practitioners -Administration Officer -Sessional Bilingual Community Educators. -Two hospital refugee pediatric clinics.
Queensland (16 per cent of national intake)	<ul style="list-style-type: none"> Hub and spoke model of Queensland Refugee Health Service (QRHS) Hub is situated at the Refugee Health Assessment Clinic at the Mater Hospital in Brisbane, Provides both state-wide and clinical functions involving one State-wide Coordinator and one Clinical Director. Clinical Services at the hub are provided by 2 nursing officers and Sessional GPs supported by one administrative officer. Besides the short-term health assessments the QRHS allows for up to 10 hours of complex health case 	Queensland Refugee Health Service is funded by the State including state-wide staff and clinical staff at hub and spokes. This is a new service that came into being in 2007/2008.

	<p>coordination for 25% of new humanitarian arrivals. This is for complex cases involving several risk factors such as history of torture and trauma, mental and physical health-multiple co-morbidity, no or poor English language proficiency, large numbers of young children and single parent families.</p> <p>The spokes include:</p> <ul style="list-style-type: none"> • Brisbane North: Health Assessment Clinic followed by referral to community GPs. • Logan: Health Assessment Clinic followed by referral to community GPs • Toowoomba: No dedicated service. Basic infectious disease screening at Toowoomba Health Service followed by referral to community GPs. • Cairns: No dedicated service. Referral to community GPs. • Townsville: No dedicated service. Referral to community GPs. • Additionally, there is the longer term complex health case intervention provided by Queensland Integrated Refugee Community Health Clinic (QIRCH). 	
<p>Northern Territory</p> <p>(1 per cent of national intake)</p>	<ul style="list-style-type: none"> • Refugee Health Screening Clinic on site at the Royal Darwin Hospital (RDH) campus which provides screening (based at the Centre for Disease Control). A part time medical officer and a part time registered nurse staff this clinic. Screening is undertaken and acute medical conditions are followed-up • During the clinic visit, treatment is provided free via RDH pharmacy for certain conditions if required • All new refugees also attend the local Community Care Centre, which is staffed by Community Care nurses for immunization catch-up and Mantoux testing. Immunizations are given according to the current NT Childhood Vaccination Schedule and the Australian Immunization Handbook • Refugees are then referred to general practitioners for their long-term primary health care 	<p>No direct funding.</p> <p>Funding is diverted from other CDC programs.</p>
<p>Western Australia (WA)</p> <p>(11 per cent of national intake)</p>	<ul style="list-style-type: none"> • When refugees arrive in Western Australia they attend Migrant Health Unit, where health assessments are conducted by a doctor and they attend the chest clinic. • As on 16th November 2010, a new 1.4 million one-stop facility has been announced to accommodate the Humanitarian Entrant Health Service and the WA Tuberculosis Control Program (ACT, 2010). • If the refugee requires extra medical treatment they are referred to the appropriate service, including dental treatment and trauma counseling. • The refugee is given a plan for health care with the doctor's recommendations. This is also given to a community migrant health nurse, who provides ongoing care through monitoring the nursing needs of refugees, conducting health promotion activities, and linking them with other specialist health services (especially outpatient clinics) and primary care in the community. 	<p>Migrant Health Unit is funded by the State and comprises .8 of Full Time Employment Medical Officer, nursing and administrative staff.</p>
<p>South Australia</p>	<ul style="list-style-type: none"> • Migrant Health Service provides: 	<p>Migrant Health Service</p>

(SA) (12 per cent of national intake)	<ul style="list-style-type: none"> ○ health assessments ○ immunization ○ support services ○ transition program to prepare refugees for private general practice. <ul style="list-style-type: none"> • The IHSS provider has an early health assessment and intervention program and refers refugees to GPs or the Migrant Health Service 	comprised of 1 Manager, 1 Medical Officer, 2.5 Full Time Equivalent (FTE) nurses, 1.5FTE social workers, 1 Clinical Psychologist, 2 Project Officers and 3 Administrative Officers.
Australian Capital Territory (ACT) (1 percent of national intake)	<ul style="list-style-type: none"> • Health services are provided through the torture and trauma service, Companion House, a non-government organization, which provides a medical service • GP consultations, Tuberculosis (TB) screening, coordination of care, and referrals to community health services are undertaken. 	Medical service coordination and computerization of the service is funded by the ACT Government.
Tasmania (2 percent of national intake)	<ul style="list-style-type: none"> • Refugee and Humanitarian Arrival Clinic (RAHAC) provides a free comprehensive health assessment to assist GPs in addressing the on-arrival health needs of refugee clients • The Clinic is based at the Royal Hobart Hospital and an outreach clinic is based at the Launceston General Hospital. 	RAHAC is staffed by paid specialists and nurses and is funded by the Tasmanian Department of Health and Human Services.

¹ based on 2006-2007 figures of DIAC settlement database

² some of the funding in all the services is through bulk billing arrangements through Medicare

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Appendix 7: Services Provided by Organizations Supporting Survivors of Torture and Trauma

State	Organization	Services Provided
Victoria	The Victorian Foundation for the Survivors of Torture (Foundation House)	Counseling, individual and group therapy, psychiatric services, rural and regional services, advocacy and referral, natural therapies ¹ .
New South Wales (NSW)	NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)	Individual and family counseling, group therapy, psychiatric services, services for young people such as camps, activity groups such as English and culture groups, enterprise facilitation, legal advice, research and training, natural therapies.
Queensland	Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)	Individual and family counseling, youth and children's programs, information sessions, personal support, community development, capacity building, training and consultancies, natural therapies
Northern Territory	Torture and Trauma Survivors Service of the Northern Territories (Melaleuca Refugee Center)	Refugee Settlement Services, counseling, advocacy, community development, natural therapies.
Western Australia	Association for Services to Torture and Trauma Survivors (ASeTTS)	Counseling, employment, youth services, community development, culturally-appropriate nutrition, family support, natural therapies.
South Australia	Survivors of Torture and Trauma Assistance and Rehabilitation service (STTARS)	Individual and group counseling, information, advocacy and support, education and training, interpreting services, natural therapies
Australian Capital Territory	Companion House (Assisting Survivors of Torture and Trauma)	Medical and primary health services, counseling community capacity building, training, natural therapies.
Tasmania	Phoenix Centre	Counseling, advocacy, community development, natural therapies.

¹ The Natural Therapies programs are presented in Table 3.2 in Chapter 3.

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Appendix 8: National Asthma Council Australia Effectiveness Scale

	Strong Evidence of Effectiveness
3+	Systematic Review finding a statistically significant and clinically important effect (without significant heterogeneity) or More than one RCT finds a statistically significant and clinically important effect, none conflicting
	Probably Effective
2+	More than one controlled trial available. A majority, but not all, of which show significant and clinically important effect
	Possibly Effective
1+	One controlled trial shows statistically significant effect
	Neutral
+/-	Randomized or non-randomized clinical trials yield conflicting results, demonstrated effects are probably not clinically important.
	Possibly ineffective
1-	One small controlled trial shows no significant effect
	Probably Ineffective
2-	More than one controlled trial available. A majority, but not all, excludes a clinically important effect (absence of effect) or One large controlled trial excludes a clinically important effect.
	Strong Evidence of Lack of Effect
3-	Systematic review excludes a clinically important effect (without significant heterogeneity) or more than one RCT excludes a clinically important effect
	Insufficient Evidence
0	Available evidence does not meet the above criteria

(Marks, Cohen et al. 2005)

Marks, G., M. Cohen, et al. (2005). Asthma and Complementary therapies: A guide for health professionals. Canberra, Australian Government Department of Health and Ageing and National Asthma Council.